Arizona Department of Health Services

Division of Behavioral Health Services
Division of Quality Management Operations

150 North 18th Avenue, Suite 240
Phoenix, Arizona 85007
(602) 364-4558
(602) 364-4749 FAX
Internet: www.azdhs.gov

JANET NAPOLITANO, GOVERNOR
JANUARY CONTRERAS, ACTING DIRECTOR

RECEIPT OF DELIVERY TO AHCCCS/DHM FROM ADHS/DBHS/QMO

DATE: **November 28, 2008**

TO: **Kristin Frounfelker**
Division of Healthcare Management
AHCCCS
701 E. Jefferson, MD - 6500
Phoenix, AZ 85034

This is to be considered an official receipt for the following:

NAME OF REPORT:

FY 2009 1st Quarter Performance Improvement Activity Report

DATE REPORT IS DELIVERED TO:
AHCCCS, Division of Healthcare Management:

RECEIVED BY (AT AHCCCS) BY:
Stewart McKinzie 11/28/08
Signature/Date

DELIVERED BY (FROM DBHS):
Michelle Ryan 11/28/08.
Signature/Date

Arizona Department of Health Services

Division of Behavioral Health Services
Division of Quality Management Operations

150 North 18th Avenue, Suite 240
Phoenix, Arizona 85007
(602) 364-4558
(602) 364-4749 FAX
Internet: www.azdhs.gov

JANET NAPOLITANO, GOVERNOR
SUSAN GERARD, DIRECTOR

November 28, 2008

Kristin Frounfelker
Behavioral Health Administrator
Division of Healthcare Management
AHCCCS
701 East Jefferson, 2nd Floor, Mail Drop 6500
Phoenix, Arizona 85034

Dear Ms. Frounfelker:

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) is pleased to submit the Quarter 1, Fiscal Year 2009, Quarterly Performance Improvement Activity Report.

If you have any questions, please feel free to contact me at (602) 364-4651, or via email at stauffs@azdhs.gov.

Sincerely,

Sondra Stauffacher
Division Chief
Performance Improvement

SS:jb

cc: Robert Sorce, ADHS/DBHS
File

Quarterly Performance Improvement Activity Report

Quarter 1 Fiscal Year 2009

Arizona Department of Health Services
Division of Behavioral Health Services
150 North 18th Avenue, Suite 240
Phoenix, Arizona 85007

Executive Summary

The Q109 Adult Quarterly Performance Improvement Report presents an analysis of RBHA specific and statewide performance on the following AHCCCS performance measures:

- Appropriateness of Services
- Sufficiency of Assessments
- Coordination of Care
- Access to Care

Performance measures data is compared to existing data sources for identification of systemic areas for improvement and include member complaints, service utilization data, Quality of Care issues, Grievance and Appeals data and RBHA specific corrective actions. The following table provides a snapshot of Child and Adult Performance Measures scores for Q109.

RBHA	Access to Care 7 Day		Access to Care 23 Day		Coordination of Care 1 (Referral)		Coordination of Care 2 (Communication)		Appropriateness of Services		Sufficiency of Assessments	
	MPS: 85%		MPS: 85%		MPS: 80%		MPS: 70%		MPS: 85%		MPS: 85%	
	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult	Child	Adult
CBH AZ 2	100%	99%	97%	94%	100%	100%	81%	81%	100%	58%	100%	100%
CBH AZ 4	98%	98%	86%	88%	N/A	50%	96%	75%	93%	85%	99%	99%
CPSA 3	99%	98%	92%	89%	100%	100%	30%	49%	80%	72%	99%	99%
CPSA 5	99%	100%	89%	84%	50%	47%	73%	73%	91%	68%	99%	99%
Maricopa	93%	87%	80%*	90%	67%	59%	64%	47%	57%	58%	96%	96%
NARBHA	95%	96%	84%	87%	70%	81%	76%	86%	91%	70%	96%	96%
SW RBHA	95%	91%	84%*	89%	74%	63%	73%	68%	85%	69%	97%	97%
Gila River	95%	94%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Pascua Yaqui	100%	97%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
White Mtn	100%	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SW TRBHA	97%	97%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Children

Strengths:

- All RBHAS exceeded the MPS on the Sufficiency of Assessments Measure;
- Initial assessments are sufficient for the provision of treatment recommendations; and
- The statewide score on Access to Care surpassed the minimum performance standard for the 7 Day standard.

Areas for Improvement:

- Coordination of Care with the Primary Care Physician (PCP)/Health Plan;
- Timely provision of ongoing services to continually enrolled members; and

- Provision of services that are appropriate to the needs of the recipient as identified on the individual service plan.

ADHS/DBHS changed its methodology in Q109 for measuring Functional outcomes to provide more meaningful analysis of where system improvements are required. Overall, outcomes improved for rates of employment, education, living at home or independently, no criminal involvement, and no substance use for the majority of the children's population, with the exception of living at home for the 0 – 4 age group.

Adults

Strengths:

- All RBHAs exceeded the minimum performance standard on the Sufficiency of Assessments Measure;
- Statewide performance improved on the Coordination of Care 2 (COC 2) and Appropriateness of Services Measures;
- The minimum performance standard was exceeded on both Access to Care standards, with most RBHAs surpassing the benchmark; and
- Comparative analysis indicates the system provides timely services to member utilizing higher levels of care and to those entering behavioral health services; and
- Initial assessments are sufficient for the provision of treatment recommendations.

Areas for Improvement:

- Ongoing communication with a member's PCP/Health Plan based on the recipient's current health status (COC 2);
- Timely communication of referral disposition back to the PCP/Health Plan;
- Provision of clinically appropriate services to continuously enrolled recipients, including timely updates to assessments; and
- Increased oversight of General Mental Health (GMH) recipient's service utilization to ensure continuity of care.

It should be noted that for the two Access to Care performance measure standards, RBHA performance is reported in reference to the minimum performance standard, Goal and Benchmark (85%, 90%, and 95% respectively)cited in the AHCCCS/ADHS/DBHS Contract. Fiscal Year 2009 (FY09) ADHS/DBHS/RBHA Contract Amendments reflect an increase in performance expectations to an MPS of 90%, Goal of 95% and Benchmark of 100%. As noted above, all RBHAs have consistently exceeded the minimum performance standard on the Access to Care 7 Day standard. ADHS/DBHS continues to provide technical assistance to the RBHAs to improve performance on the Access to Care 23 Day Measure.

The following report includes detailed analysis of the performance measures and includes supporting data from the functional areas within ADHS/DBHS. Recommendations for RBHA specific and statewide corrective actions to drive system improvement for both populations are included in the body of the report and tracked through the ADHS/DBHS Quality Management (QM) Committee and sub-committees.

Children's System of Care Quarterly Report

This quarterly report presents an analysis of the numerous quality assurance activities undertaken by the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) in monitoring performance and outcomes in the Children's System of Care across Arizona. Statewide performance on the required AHCCCS performance measures is reported, as are additional data from various other Quality Management (QM) data feeds. Information in this report is utilized to initiate quality improvement activities to further the ADHS/DBHS Arizona Vision and Twelve Principles for the Children's System of Care.

The Arizona Vision states:

> *In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.*

This Vision outlines the 12 Arizona Principles:

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

ADHS/DBHS utilizes its Children's Quality Management Committee, comprised of representatives across all Division functional areas with content expertise, to review and respond to the vast amount of incoming information that reflects performance and progress in establishing a functioning and sustainable children's system of care that practices according to the 12 Arizona Principles. This report is meant to effectively pull information from the following input sources to provide a clear view of overall system performance. Information and data input sources for this quarterly report include:

- AHCCCS statewide performance measures[1]:
  - Appropriateness of Services,
  - Sufficiency of Assessments,
  - Coordination of Care, and
  - Access to Care,
- Consumer complaints
- Follow-up after Discharge from Level I Facility
- Service utilization
  - Out-of-Home placements

[1] *Arizona Department of Health Services, Division of Behavioral Health Services Performance Improvement Specifications Manual* describes the methodologies for the performance measures and supporting data collections (*Attachment A*).

- Child and Family Team Practice Reviews
- Functional Outcome Measures

Future reports will also include relevant findings from Consumer Satisfaction Surveys (which address Principle 10: *Respect for the child and family's unique cultural heritage*), Quality of Care concerns, additional service utilization data, Clinical Practice Protocol monitoring reviews, and other pertinent data elements as results are reported.

Appropriateness of Services

Definition

Appropriateness of Services is assessed through a chart review conducted quarterly by the ADHS/DBHS Office of Monitoring and Oversight to determine if the types and intensity of services, including case management, are provided based on the client's assessment and treatment recommendations. Ten records for the TXIX/XXI child population are randomly selected per Geographic Service Area (GSA). The small sample size is a data limitation for this measure.

Arizona Principles Monitored

The Appropriateness of Services measure assists ADHS/DBHS in monitoring performance related to Arizona Principle 1: *Collaboration with the Child and Family*, Principle 2: *Functional Outcomes*, Principle 4: *Accessible Services*, Principle 7: *Timeliness;* Principle 8: *Services Tailored to the Child and Family* and Principle 12: *Connection to Natural Supports*. This measure ensures individuals have appropriate Individual Service Plans (ISPs) that are tailored to the needs of the child and family and receive the identified services outlined in the ISP.

Calculation

$$\frac{\text{Number of Charts Reviewed Scored "Yes" on Questions 72, 74 and 75 of Universal Review Tool}}{\text{Total Number of Charts Reviewed}}$$

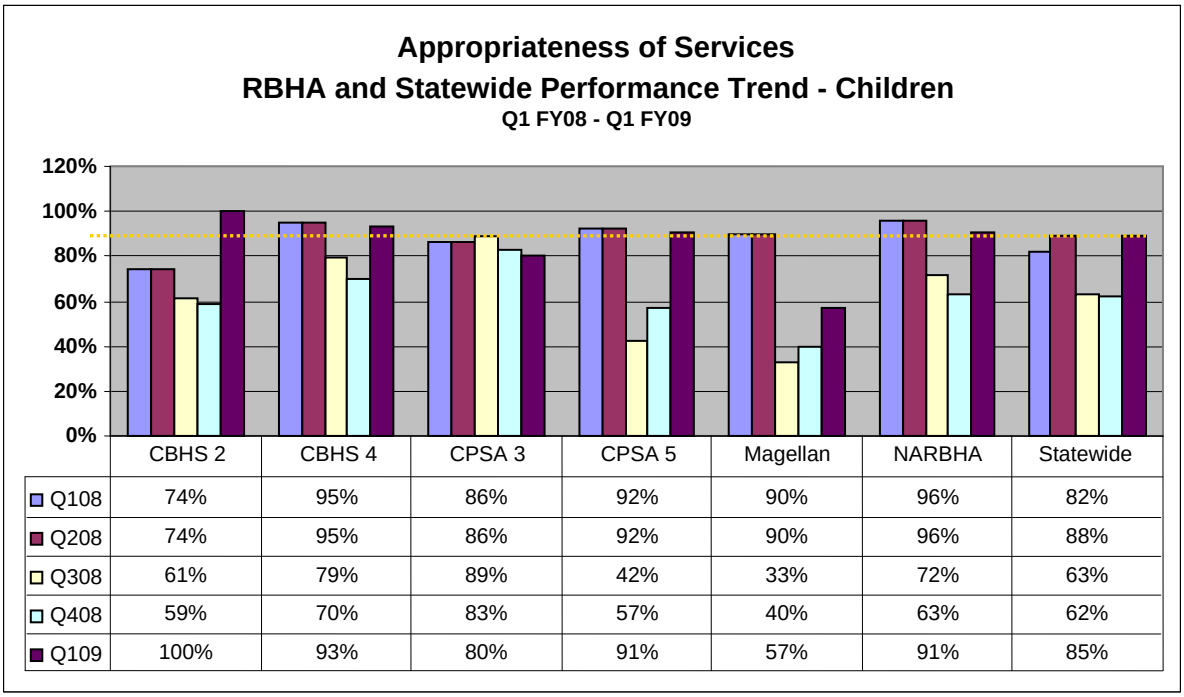
Question 72: Treatment plans for children utilize both formal and informal/natural supports and services. (Principle 12)
Question 74: Treatment plans for children identify outcomes, actions, and strategies/interventions/tasks related to the family vision for the future. (Principles 1 and 8)
Question 75: Treatment plans for children include measures by which the Child and Family Team can monitor progress. (Principle 2)

To score 'yes' on any of these questions, the corresponding service must be provided (Principle 4) within the time frame identified in the treatment plan (Principle 7). A score of 'yes' on all three questions is required to score positively on this measure.

The minimum performance standard (MPS) for this measure is 85% with a goal of 90% and a benchmark of 95%.

Figure A below depicts statewide performance on this measure over FY08 to Q109. Results for this measure are reported on a quarter delay due to the amount of time required to identify a sample and staff resources to conduct the in-depth review.

Figure A.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	74%	95%	86%	92%	90%	96%	82%
Q208	74%	95%	86%	92%	90%	96%	88%
Q308	61%	79%	89%	42%	33%	72%	63%
Q408	59%	70%	83%	57%	40%	63%	62%
Q109	100%	93%	80%	91%	57%	91%	85%

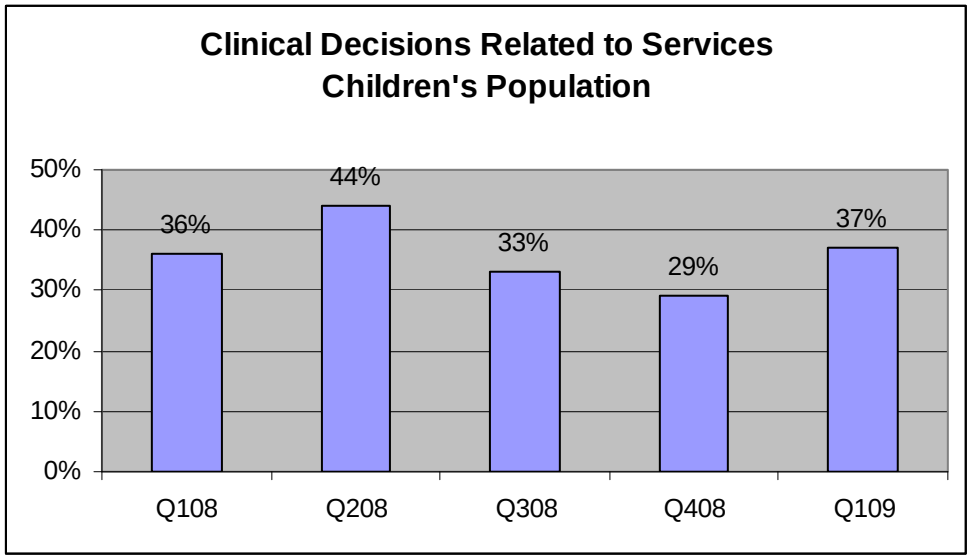
Statewide performance on this measure fluctuated over the year with the lowest performance rates during Q308 and Q408. Q109 scores increased again to meet the minimum performance standard (MPS) of 85%. Outliers were seen in CPSA-3 and Magellan. This is the second quarter in which CPSA-3 fell below the MPS and the third consecutive quarter where Magellan has significantly failed to meet the MPS. As noted above, each quarter represents a sample size of 10 records for the Title XIX/XXI children's population. ADHS/DBHS will be aggregating the results each quarter during FY 09 to include previous quarters' data to provide a more representative analysis on this measure given the small sample sizes used.

Further analysis of the results suggests a disconnect between the treatment recommendations in the individualized service plans and the Covered Services that are actually being provided. For Magellan, significant issues related to poor documentation and medical record filing contribute significantly to its low scores as reviewers noted that the majority of the medical records appeared to be incomplete. However, poor documentation appears to be a statewide issue. It is believed that service plans are not being updated when indicated, as reviewers noted that treatment plans were not consistently reflective of the recipients' current status. Results of this measure are consistent with information garnered from statewide consumer complaints, as discussed below.

The largest numbers of Child complaints filed by all program types in Q109 were captured in the *Clinical Decisions Related to Services Category*, consistent with data reported over FY08 (Figure B). For Q109, the rate of complaints in this category was at 37% (44 out of 118 complaints in Q109, statewide). The sub-category of *Assessment/Service Plan Content*, which captures complaints pertaining to the types, frequency and intensity of Covered Services provided to the member as outlined in their individual service plan, contributed to 50% (22 of 44 complaints) of the overall complaints in this category. The Covered Service category most frequently cited is *Medication Services*, at a rate of 23% (10 out of 44 complaints). Further analysis of this category by GSA reveals the majority occurred in CPSA-5 (N=32). The remaining were relatively evenly distributed across the GSAs with Magellan at 5, CPSA-3 at 4, CBHS-4 had 3, and both CBHS-2 and NARBHA had 0.

Although trends suggest that this category contributes the largest number of complaints, it represents 44 complaints for 36,851 Title XIX/XXI enrolled children (September 2008 enrollment data).

Figure B.



To summarize, statewide performance on this measure meets the MPS of 85%, with Magellan and CPSA-3 as outliers. However, complaint data suggests that statewide, recipients complain most frequently about the types, frequency and intensity of Covered Services provided as outlined in their individual service plan, particularly medication services.

Actions taken

The results of this performance measure are reviewed in the ADHS/DBHS Children's Quality Management Committee and in the ADHS/DBHS RBHA Quality Management Coordinators' Meetings. The ADHS/DBHS Clinical and Network Operations departments are providing technical assistance across the state to address service-planning quality. CPSA-3 and Magellan are required to submit corrective action plans to address poor performance concerns with this measure. These plans will be reviewed for appropriateness and the results tracked by the QM Committee to ensure improvements are made. Issues related to poor documentation will be addressed with the RBHA Quality Management Coordinators to develop actions for improvement.

Sufficiency of Assessments

Definition

The Sufficiency of Assessments performance measure evaluates the completeness of the initial assessment for all TXIX/XXI children, to determine if there is sufficient information included to develop functional treatment recommendations. This is measured through the demographic submissions to the Client Information System (CIS) by counting the number of records that are accepted by the system as complete, meaning that all required assessment fields contain valid values.

Arizona Principles Monitored

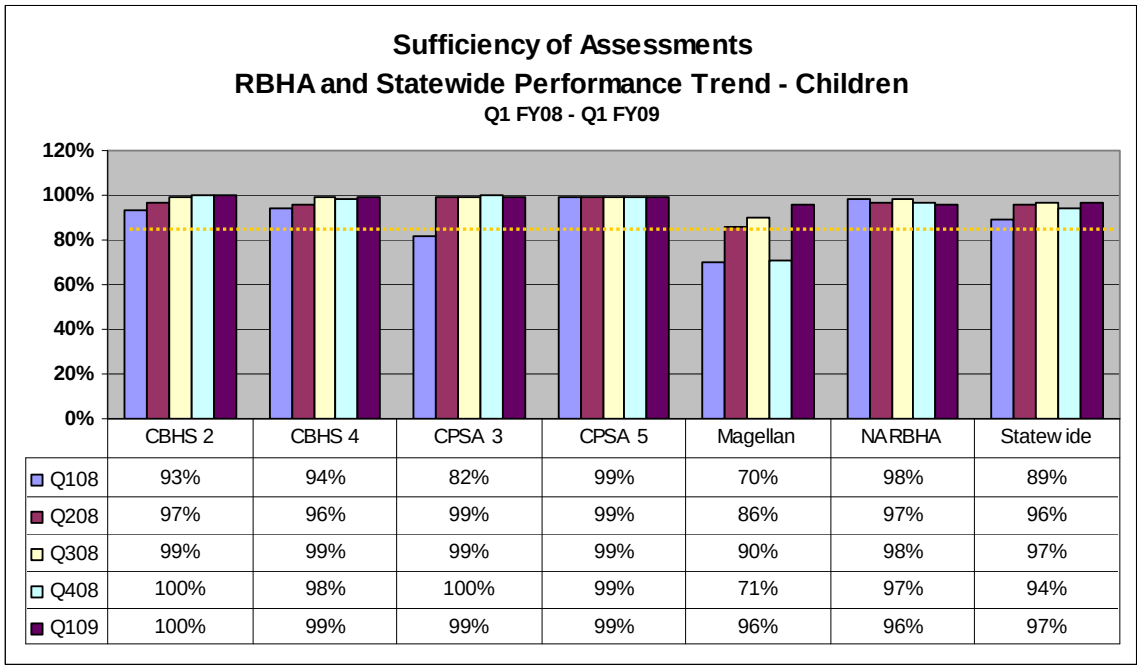
The Sufficiency of Assessments measure assists ADHS/DBHS in monitoring performance related to Arizona Principle 4: *Accessible Services* and; Principle 7: *Timeliness.* This measure confirms that Title XIX/XXI recipients have access to and receive a complete, comprehensive behavioral health assessment within 45 days of initial enrollment.

Calculation

$$\frac{\text{Number of Accepted Demographic Submissions with completed assessment fields}}{\text{Total Number of Demographic Submissions to ADHS/DBHS CIS}}$$

The MPS for this measure is 85% with a goal of 90% and a benchmark of 95%.

Figure C.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	93%	94%	82%	99%	70%	98%	89%
Q208	97%	96%	99%	99%	86%	97%	96%
Q308	99%	99%	99%	99%	90%	98%	97%
Q408	100%	98%	100%	99%	71%	97%	94%
Q109	100%	99%	99%	99%	96%	96%	97%

Figure C above shows the results for the previous year and Q109. Statewide performance on this measure continues an upward trend from Q108 and continues to meet the MPS of 85%. Of note is that Magellan improved its performance score by 25 percentage points this reporting quarter. Magellan is operating under increased technical assistance by ADHS/DBHS to continue improvement in its data submissions, as evidenced in the RBHA's improved Q109 measurement.

This measure is focused on the sufficiency of the initial assessment. ADHS/DBHS has recently implemented a supporting method to assess the quality of assessment updates. The Quality of Assessments measure is assessed through a chart review and evaluates the quality of the updated assessments to determine if they are sufficient to continue making functional treatment recommendations. Results of the chart review for Q109 will be presented in the Q209 report. Preliminary results suggest that the system is performing well in terms of completing assessments for newly enrolled members, but has difficulty maintaining the quality of ongoing assessments. This information supports the findings related to the Appropriateness of Services measure, indicating that individuals are not receiving services according to the needs identified on the service plan due to lack of timely updates to the assessment and individual service plan based on the member's current needs..

Actions Taken

The results of this performance measure are reviewed in the ADHS/DBHS Quality Management Committee and in the Quality Management Coordinators meetings that occur between ADHS/DBHS and the RBHAs. As all RBHAs are exceeding expectations on the performance measure, no corrective measures were deemed necessary. ADHS/DBHS will continue to monitor the sufficiency of initial assessments and quality of ongoing assessments quarterly.

Coordination of Care

Coordination of Care (COC) looks at two measures to assess compliance with coordinating behavioral health services with the Primary Care Physician (PCP)/ Health Plan.

Arizona Principles Monitored

Coordination of Care provides information related to the system's performance on Principle 3: *Collaboration with Others* and is considered Best Practice.

COC 1 (Referral)

Definition

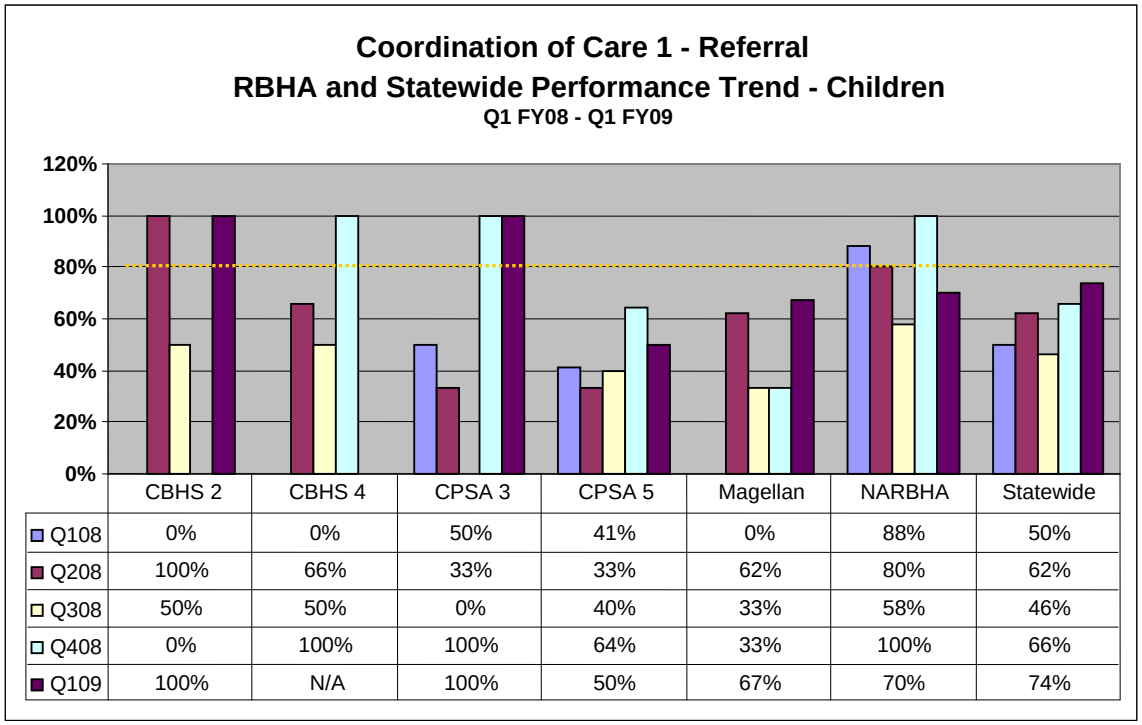
COC 1 determines if the RBHA has communicated the disposition of the referral to the AHCCCS Health Plan or PCP for TXIX/XXI children referred for behavioral health services, within the required timeframes. A limitation of this data is that the 'n' size may be small as it is dependent on the number of individuals referred by the PCP or Health Plan. Figure D shows the trends across the past year to this reporting quarter.

Calculation

$$\frac{\text{Number of Charts Containing Referral Disposition Documentation}}{\text{Total Number of Charts Reviewed}}$$

The MPS for this measure is 80%, with a goal of 90% and a benchmark of 95%.

Figure D.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	0%	0%	50%	41%	0%	88%	50%
Q208	100%	66%	33%	33%	62%	80%	62%
Q308	50%	50%	0%	40%	33%	58%	46%
Q408	0%	100%	100%	64%	33%	100%	66%
Q109	100%	N/A	100%	50%	67%	70%	74%

Although statewide performance in Q109 increased 24 percentage points from the same quarter last year, and has steadily improved since Q308, it is still below the MPS. CBHS 2 surpassed the minimum standard of 80%. It should be noted that CPSA 3 scored 100% on this measure for the past two quarters. CBHS 4 scored N/A because no children were identified as being referred by the Health Plan or PCP at the time the sample was pulled. A limitation of this measure is the small 'n' size, which may account for the significant changes from one quarter to the next. Specific 'n' sizes related to this and all measures can be found in *Attachment D*. ADHS/DBHS will aggregate the results for each quarter of FY09 including the previous quarters' data to conduct a more viable analysis of this measure.

COC 2 (Communication)

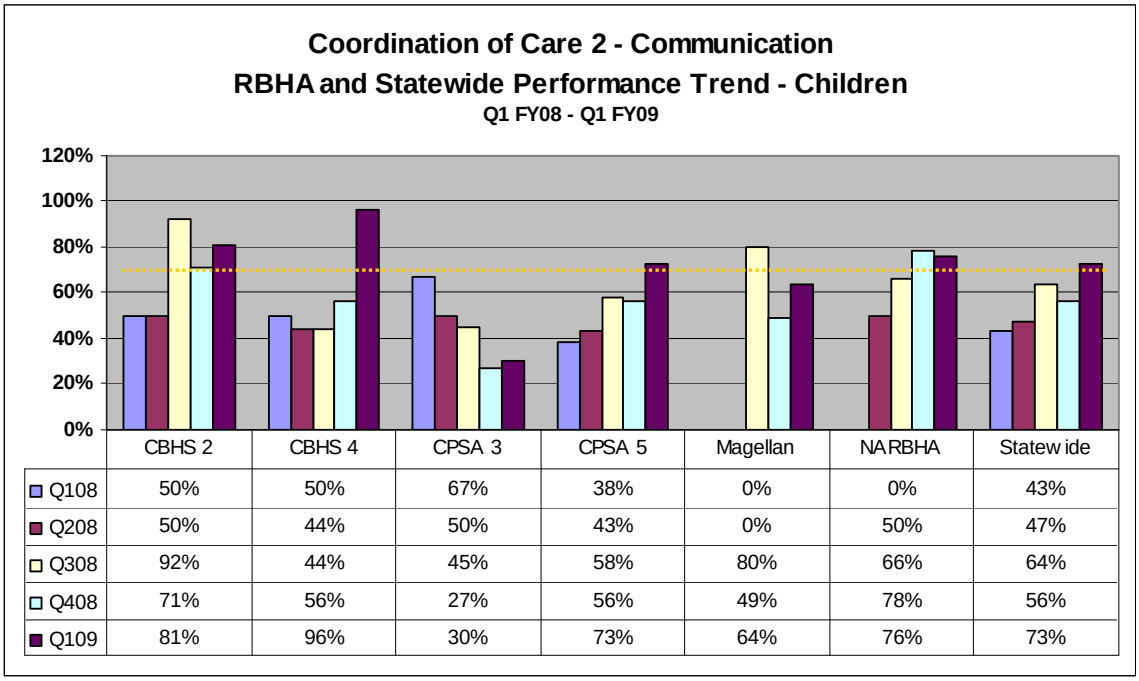
Definition

COC 2 assesses ongoing communication with the PCP/Health Plan for Title XIX/XXI behavioral health recipients who have a chronic medical condition on Axis III and/or are SMI. Data is pulled from ADHS/DBHS' CIS quarterly to identify recipients in each Geographical Service Area (GSA) who meet the criteria for coordination of care. If the sample frame for a GSA is at or below 100, the entire population is used to calculate the measure. If the sample frame is above 100, a sampling method that ensures a 90% confidence interval and 5% error rate is employed. Figure E shows the trends across the past year.

Calculation: $\frac{\text{Number of Charts Containing Documented COC Attempts with PCP}}{\text{Total Number of Charts Reviewed}}$

The MPS is 70%, with a goal of 80% and a benchmark of 90%.

Figure E.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	50%	50%	67%	38%	0%	0%	43%
Q208	50%	44%	50%	43%	0%	50%	47%
Q308	92%	44%	45%	58%	80%	66%	64%
Q408	71%	56%	27%	56%	49%	78%	56%
Q109	81%	96%	30%	73%	64%	76%	73%

Performance on this measure continues an upward trend with a significant 17 percentage point improvement achieved in Q109, meeting the MPS for the first time under the current methodology. Outliers were seen in Magellan and CPSA-3, both of which failed to meet the MPS. CPSA-3 has consistently performed poorly on this measure, scoring only a 30% in Q109.

Combined Analysis

Coordination with the behavioral health recipient's PCP or Health Plan requires continued improvement efforts. Barriers to compliance on both measures include documentation issues, including the lack of or no documentation of the coordination with the PCP; the documentation of attempts are not timely or clearly identifiable (e.g., variation in how the attempt is documented) and; the direct service providers often are uninformed as to the members' PCP assignment. In addition, there is a need for increased oversight of the referral process by the RBHA and of the direct services sites to ensure that processes are in place for timely coordination.

Actions Taken

All RBHAs implemented Corrective Action Plans (CAPs) due to poor performance on this measure, with ongoing monitoring, oversight, and evaluation of performance and CAP progress by the ADHS/DBHS QM Committee and Contract Compliance. CPSA Member Services implemented a health plan referral improvement activity whereby all AHCCCS referrals are reviewed by CPSA and assistance is offered to the direct service providers in setting up the initial appointments. Magellan is revising its processes for responding to referrals from Health Plans with ADHS/DBHS providing strict oversight. Sanctions were issued to CBHS-4, CPSA-3 CPSA-5, and Magellan for repeated non-compliance to the Coordination of Care measures. Technical assistance is routinely provided on this measure by ADHS/DBHS, including documentation requirements and the timeframes for reporting disposition of referral and referral log errors.

Access to Care

Access to Care consists of two measures evaluating compliance to the required timeframes for providing services after referral.

Arizona Principles Monitored

Access to Care provides information related to the system's performance on Principle 4: *Accessible Services* and; Principle 7: *Timeliness*. This measure assesses access to and timeliness related to the initial appointment and the first follow-up service.

Definition

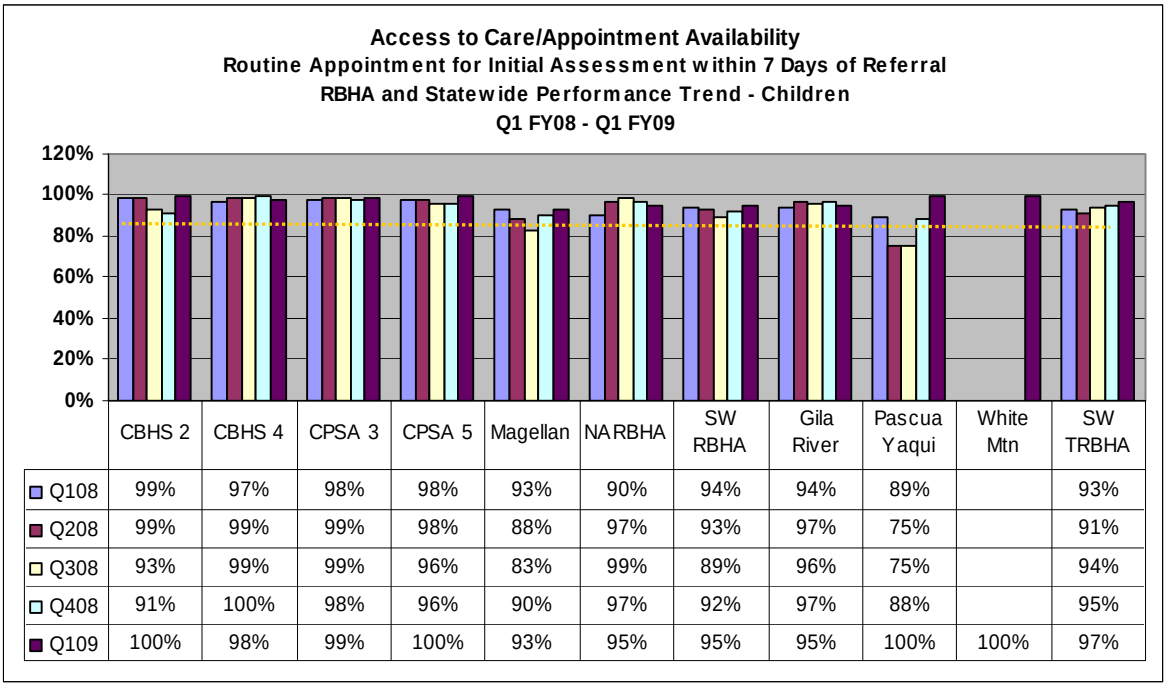
The 7-day measure looks at the number of days between the referral date and the first appointment offered to TXIX/XXI children to ensure that it occurs within 7 days. Figure F shows the trends of this measure across the past 4 quarters and includes information on the Tribal Regions in addition to the GSAs. This is the first quarter for collecting information on White Mountain Apache Behavioral Health; trending will begin from this point forward.

Calculation

Number of Referrals with <=7 days from Referral Date to First Appointment Offered Date
Total Number of Referrals Submitted by T/RBHA
= Percent in Compliance

The MPS is 85%, with a goal of 90% and a benchmark or 95%.

Figure F.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	SW RBHA	Gila River	Pascua Yaqui	White Mtn	SW TRBHA
Q108	99%	97%	98%	98%	93%	90%	94%	94%	89%		93%
Q208	99%	99%	99%	98%	88%	97%	93%	97%	75%		91%
Q308	93%	99%	99%	96%	83%	99%	89%	96%	75%		94%
Q408	91%	100%	98%	96%	90%	97%	92%	97%	88%		95%
Q109	100%	98%	99%	100%	93%	95%	95%	95%	100%	100%	97%

All RBHAs scored above the MPS of 85% and, with the exceptions of Magellan, exceeded the benchmark of 95%. Statewide (SW) RBHA performance for the Children's population was 95%. Gila River scored 95%, White Mountain Apache 100%, and Pascua Yaqui, for the first two months of the quarter, 100%, for a statewide (SW) TRBHA score of 97%. It should be noted that Pascua Yaqui is currently unable to pull September data from its client information system, ClaimTrack. The tribe is attempting to resolve the issue through technical assistance from ClaimTrack, but as of this writing is unable to provide ADHS/DBHS with an estimate of when data will be available. Pascua Yaqui's performance for Q109 will be stated in ADHS/DBHS' Q209 report.

23 Day Measure

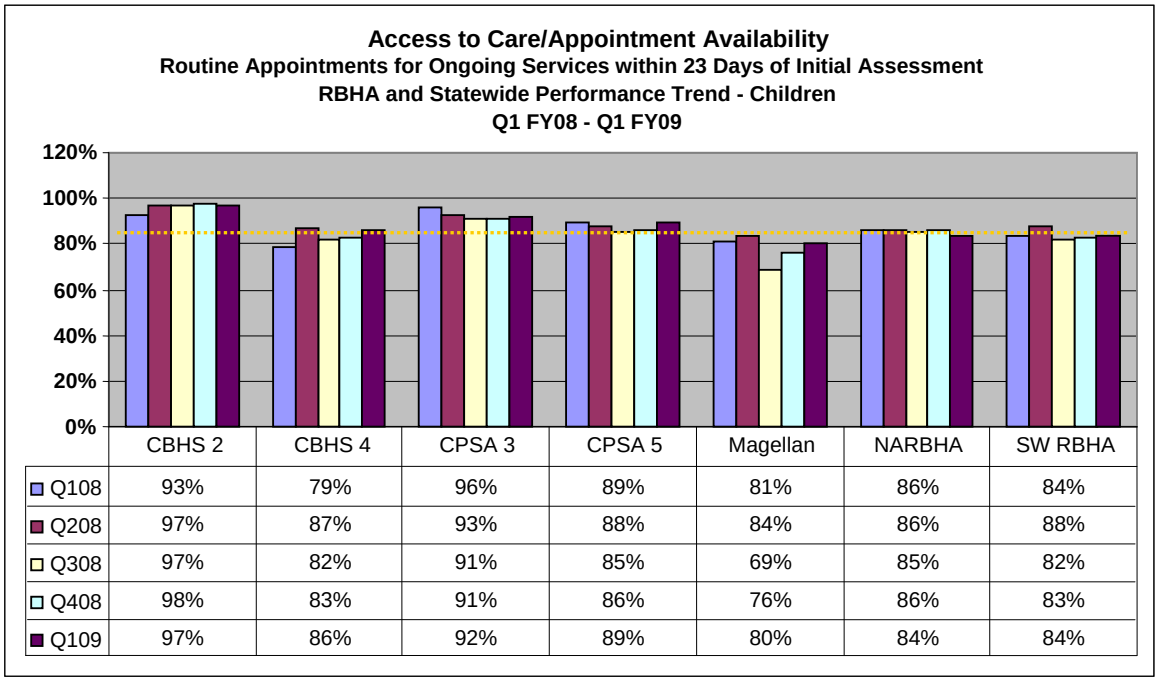
The 23-day measure looks at the number of days between the initial assessment and the first service provided to TXIX/XXI children to ensure that it occurs within the required 23 days. The data for this measure is refreshed quarterly to capture any new encounters submitted for dates of service that occurred during the time periods presented in the report. Figure G shows the trends of this measure across the past 4 quarters.

Calculation

$$\frac{\text{Number of TXIX/XXI behavioral health recipients with an intake during the quarter and a corresponding assessment encounter within 45 days of the intake date and with an ongoing service encounter within 23 days of assessment}}{\text{Total number of TXIX/XXI behavioral health recipients with an intake during the quarter and a corresponding assessment encounter within 45 days of the intake date ("usable" intakes)}} = \text{Percent in Compliance}$$

The MPS is 85%, with a goal of 90% and a benchmark or 95%.

Figure G.

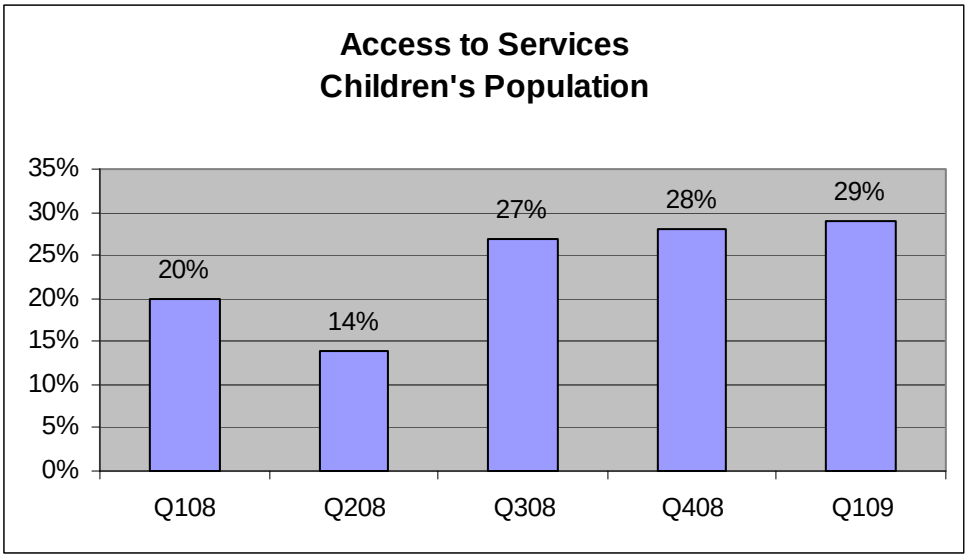


	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	SW RBHA
Q108	93%	79%	96%	89%	81%	86%	84%
Q208	97%	87%	93%	88%	84%	86%	88%
Q308	97%	82%	91%	85%	69%	85%	82%
Q408	98%	83%	91%	86%	76%	86%	83%
Q109	97%	86%	92%	89%	80%	84%	84%

Statewide performance for Q109 falls just short of the MPS at 84% with all RBHAs exceeding the 85% requirement except Magellan at 80% and NARBHA falling just shy at 84%.

While the findings on both measures show an improvement in statewide performance in Access to Care, an analysis of complaint data consistently has found the *Access to Services* category among the top 3 highest complaints with 34 complaints out of 118 complaints overall in Q109, statewide (Figure H), suggesting that the timeliness of ongoing services may be an issue.

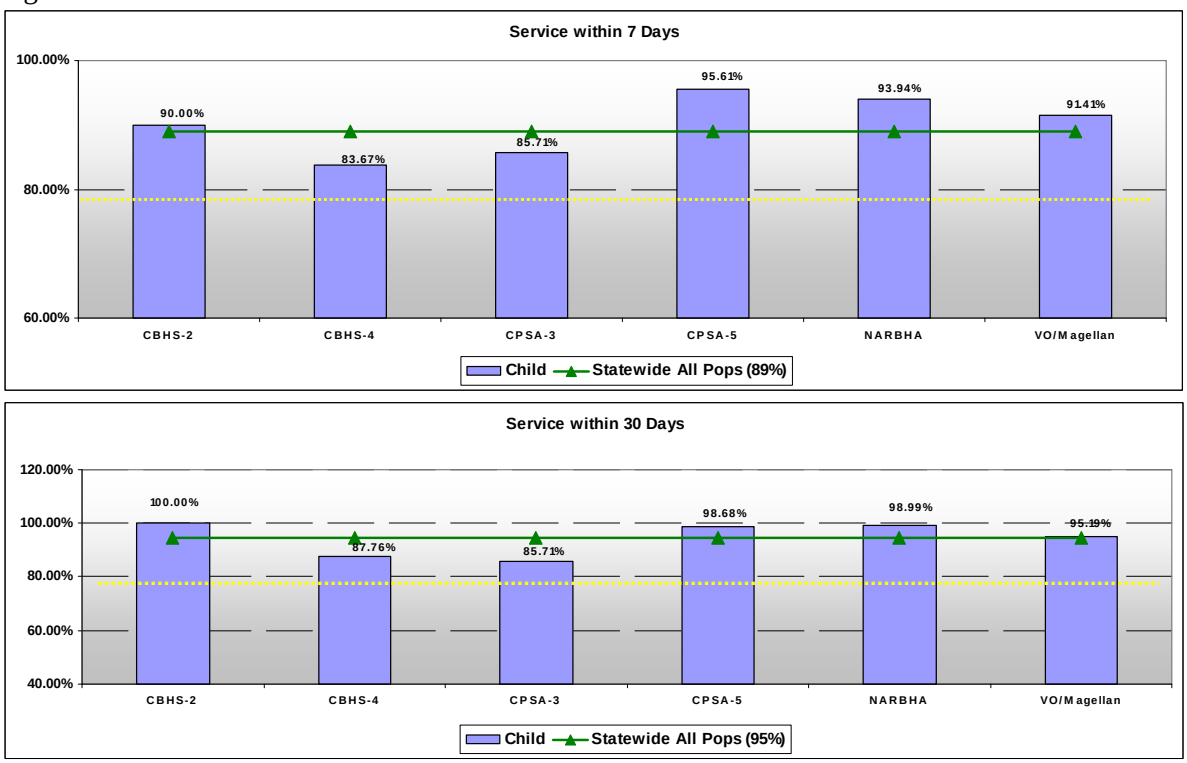
Figure H.



The sub-categories contributing to the overall complaint rate for *Access to Services* is *Timeliness* with 15 complaints *and No Provider to Meet Needs,* with 8 complaints statewide. These sub-categories capture complaints pertaining to services being provided in a timely manner and recipient's concerns that a certain provider type is not available to them for a covered service. The Covered Service category most frequently cited in relation to the Access to Services complaints is *Treatment Services,* which includes services such as counseling and assessment, at a rate of 56% (19 out of 34 complaints), followed by *Support Services* at a 24% rate (8 out of 34 complaints). The distribution of complaints across the GSAs had CPSA-5 with 16, Magellan with 13, CPSA-3 with 3, both CBHS-4 and NARBHA with 1, and CBHS-2 with 0.

Additional supporting data for the Access to Care measure is found in the *Follow-up Service after Discharge* standard. This assesses compliance with providing a behavioral health service within the required timeframes (7 days and 30 days) following a discharge from a Level 1 Inpatient facility. This measure utilizes encounter data; therefore, it is reported on a delay. The MPS is 79% for both the 7 and 30 day measures. Both timeframes were met by all RBHAs as shown in Figure I. Together with the Access to Care complaint trends, data suggests RBHAs are meeting requirements related to timeliness for newly enrolled members and follow-up after discharge; however, network sufficiency issues may be related to Treatment and Support services for ongoing timeliness of services.

Figure I.



Actions Taken

Results of the Access to Care and supporting measures were discussed in the ADHS/DBHS Children's Quality Management and Utilization Management committees. The Committee decided to increase the minimum performance standards for the Follow-up Services after Discharge measure, to 90% for the 7-day measure and 95% for the 30-day measure.

ADHS/DBHS continues network expansion initiatives to better address ongoing access to needed services, including Support and Rehabilitation Services, Generalist Type; Case Management and; Substance Abuse Treatment through an increase in Capitation rate allocations. *Attachment B* details the funding allocations and resulting approximate Full Time Equivalent (FTEs) staff positions for Support and Rehabilitation Services. Case manager expansion is tracked through bimonthly inventories submitted to ADHS/DBHS by the RBHAs. At this time, there are 165.3 FTE case managers dedicated to serving the high needs population. *Attachment C* is a summary of the case manager expansion efforts per GSA. Substance Abuse Treatment program expansion efforts are summarized in *Attachment G*.

Child and Family Team Practice Reviews

Background

As part of its overall quality management system for children, ADHS/DBHS uses the Wraparound Fidelity Assessment System (WFAS) to assess fidelity of Child and Family Team (CFT) practice in serving children with high needs. Interviews with the youth and/or family members and other key CFT participants are conducted by family organizations utilizing the Wraparound Fidelity Index 4.0 (WFI-4) Tool. In-depth chart reviews are conducted by RBHA staff utilizing the Document Review component of the WFAS. Results of the comprehensive reviews are provided to the service agency through a feedback session so clinical practice improvement efforts can be initiated. The review sample is based on children who are considered to have high needs and have been receiving behavioral health services through the CFT process for at least the past 90 days. Two months prior to the scheduled review period the service provider agency submits a list of children meeting the identified criteria for having high needs. RBHAs then randomly select a sample of 2% of the children per provider, with a sample minimum of 5 cases per agency. Children with previously completed reviews are not reviewed again for that fiscal year.

Arizona Principles Monitored

The CFT Practice Improvement Reviews assist in monitoring the system according to all 12 Arizona Principles. The WFAS provides information based on the 10 elements of wraparound; however, these 10 elements were cross-walked with the 12 Principles and include all the same fundamental principles.

Calculation

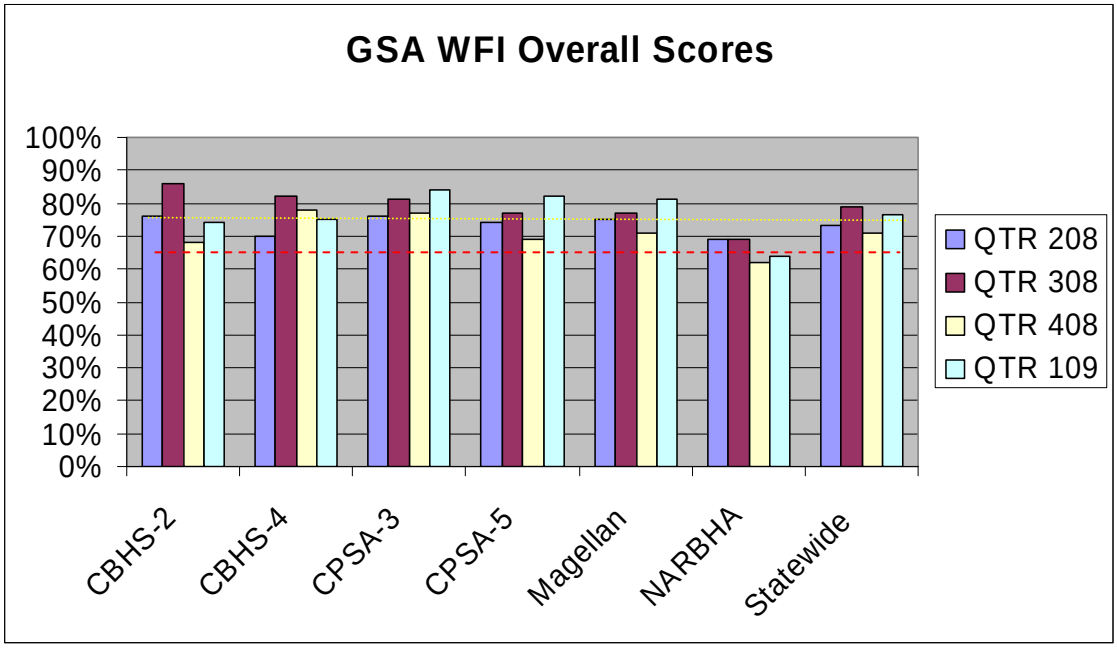
$$\frac{\text{Sum of the scores for all valid responses*}}{\text{Total possible score for all valid responses*}}$$

(*valid responses exclude those answered as N/A, refused, did not know, or were missing)

The minimum fidelity score is 65%, with satisfactory fidelity at 75% and high fidelity at 85%. Performance improvement plans are required from the provider agencies that fall below 75%.

Figure J shows the scores per GSA of the Wraparound Fidelity Index 4.0 (WFI-4) interview scores over the past 3 quarters. As each DSA is interviewed once per six months, each quarter represents a different group of provider reviews. Although a quarterly score by GSA rolls-up scores of multiple providers, it should be noted that for Q208 in CBHS-2 and Q308 in CPSA-3 only one provider was reviewed in each due to the low number of enrolled high-needs children at the scheduled provider sites. This is likely due to the low number of child providers in those regions and the somewhat subjective manner in which high needs children were identified. Implementation of the Child and Adolescent Service Intensity Instrument (CASII) should improve the process for identifying high needs children and resolve that concern. NARBHA has consistently fallen below the satisfactory fidelity standard of 75%, with the two most recent review cycles falling below the minimum fidelity standard of 65%.

Figure J.



Actions Taken

ADHS/DBHS required a Corrective Action Plan from NARBHA to address low results on the CFT Practice Reviews.

Modification efforts to the CFT Practice Review process are currently underway. ADHS/DBHS and stakeholders are using lessons learned in order to improve the quality of information collected and the helpfulness of feedback to the providers. One outcome is the implementation of a feedback template that requires a collaborative process between the family interviewers and the RBHA reviewers prior to the feedback session with the providers; this feedback requirement reinforces that the WFAS is intended to drive practice improvement.

ADHS/DBHS continues its work on development of review processes for moderate-needs and low-needs children as well.

The Child and Adolescent Service Intensity Instrument (CASII) implementation rolled out on 7/1/08 and CASII scores are now being collected in the CIS system. ADHS/DBHS Clinical Practice Improvement provided extensive technical assistance (TA) sessions on the CFT and CASII Practice Protocols to T/RBHA and Provider staff around the state. These TA sessions addressed ADHS/DBHS' expectation on the integration of the CASII tool into CFT practice and the use of this tool in accurately identifying the service intensity needs of children. With the assistance of the CASII score, CFTs decide which children need identified Case Managers and which children are considered high-, moderate-, or low-needs for CFT Practice reviews. A two-day training on the CASII tool was held November 12 and 13, 2008 to assist T/RBHA quality management staff in improving their CASII score monitoring as part of the CFT Practice review process.

Outcomes

Arizona Principle 2: *Functional Outcomes* addresses the need to obtain positive outcomes for children receiving behavioral health services, including success in school, living with their families, avoiding delinquency, and becoming stable and productive adults. Other Principles addressed through the monitoring of outcomes include Principle 6: *Most Appropriate Setting*, Principle 9: *Stability*, and Principle 11: *Independence*.

Due to the identification of several flaws with the previous methodology for monitoring outcomes (i.e. subjective nature of the scoring; lack of a scientific basis in supporting the data received; and difficulty interpreting the results given the multiple definitions for each measure), ADHS/DBHS worked with AHCCCS to change the methodology beginning with Q109. An internal workgroup was established and consisted of clinical and quality management staff to identify a new collection method to be consistent with national measures.

Since ADHS/DBHS also collects information for the SAMHSA National Outcome Measures (NOMs), it was decided to use this collection method to capture functional outcomes for children as well. ADHS/DBHS developed a methodology that includes individuals who have two points of reference in CIS. The points of reference include:

- Initial intake/assessment and first assessment update;
- Initial intake/assessment and closure;
- Assessment update and closure and;
- Two assessment updates.

Data is collected based on identified age bands:

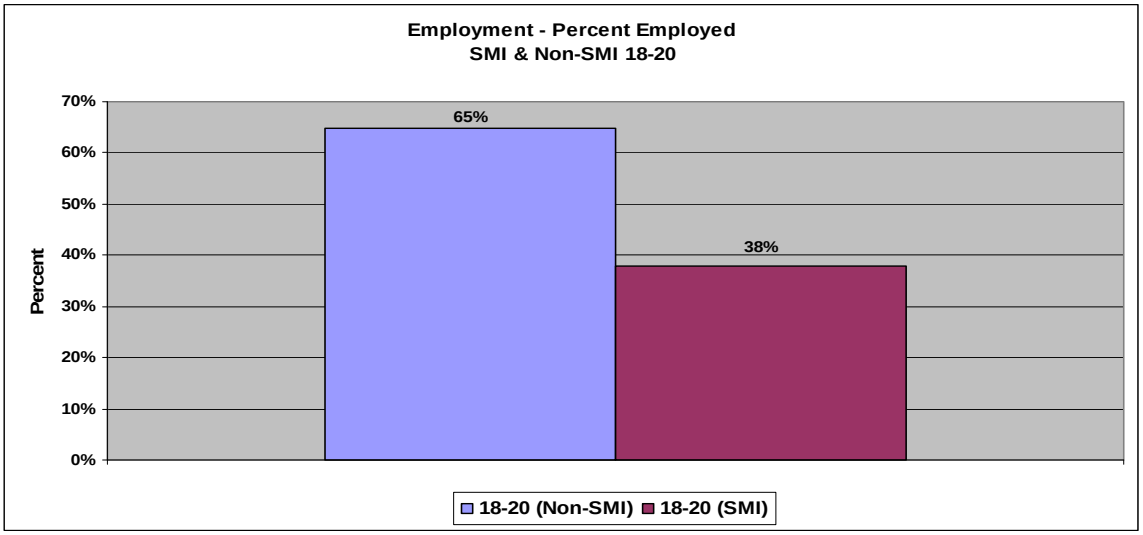
- 0-4 years of age (<5 years)
- 5-11 years of age (<12 years)
- 12-17 years of age (<18 years)
- 18-20 years of age (<21 years)

Attachment E includes tables with the raw data used in the calculations of the outcomes, including the n sizes.

<u>Employment</u>

Employment outcomes are measured for the 18 – 20 year old age bands. Figure K shows the rate of employment for behavioral health recipients aged 18-20 for Q109. Data is represented by the SMI and Non-SMI populations.

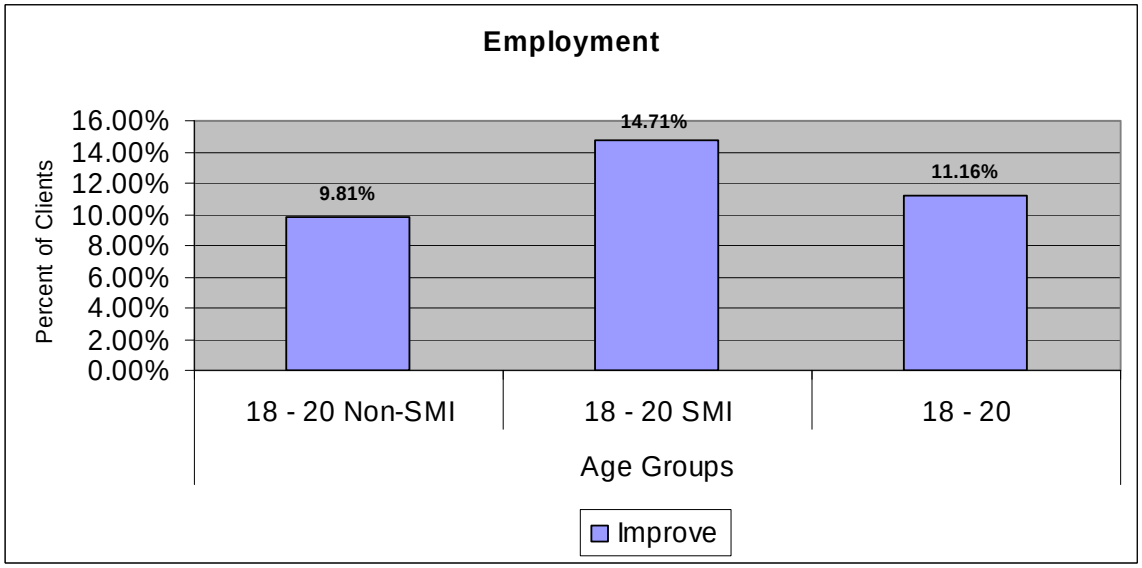
Figure K.



In Q109, the SMI population was employed at a rate of 38%, compared to the Non-SMI population employment rate of 65%. Valid values include employment with or without support, part-time or full-time; student; volunteer or; unpaid rehabilitation activities. The remaining population is accounted for under other categories, including disability, homemaker and inmate of an institution.

As demonstrated by Figure L, further analysis of the employment outcomes shows that an improvement in employment status from the first reference point (e.g. initial assessment) to the second (e.g. assessment update) occurred at a rate of 14.71% for the SMI population and 9.81% for the Non-SMI population. Improvement is noted when the behavioral health recipient moved from employment with support to employment without support or from an unemployed status to any other valid value.

Figure L.



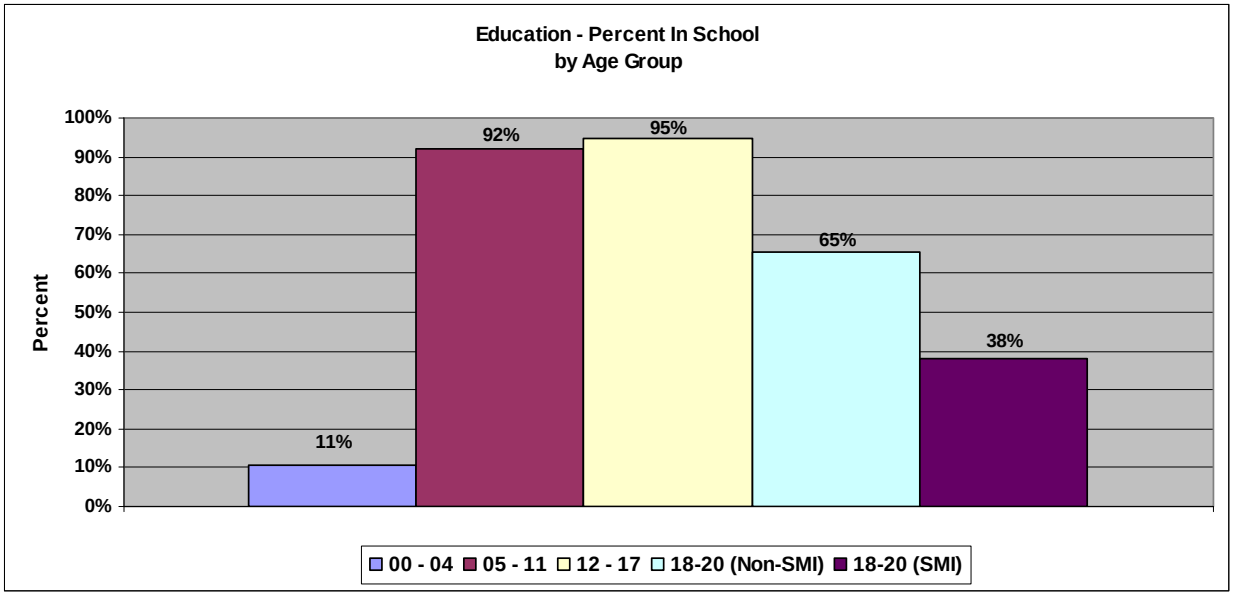
Actions Taken

ADHS/DBHS considers a recipient's involvement in employment and/or rehabilitation activities vital to recovery; a Performance Improvement Project (PIP), *Recovery through Employment* was proposed to AHCCCS in October 2008 to further highlight its significance. This PIP will focus on increasing psycho-educational and rehabilitation services to increase a recipient's involvement in employment activities, as well as training for service providers on including these services and employment goals as part of the recipients' service plans.

Education

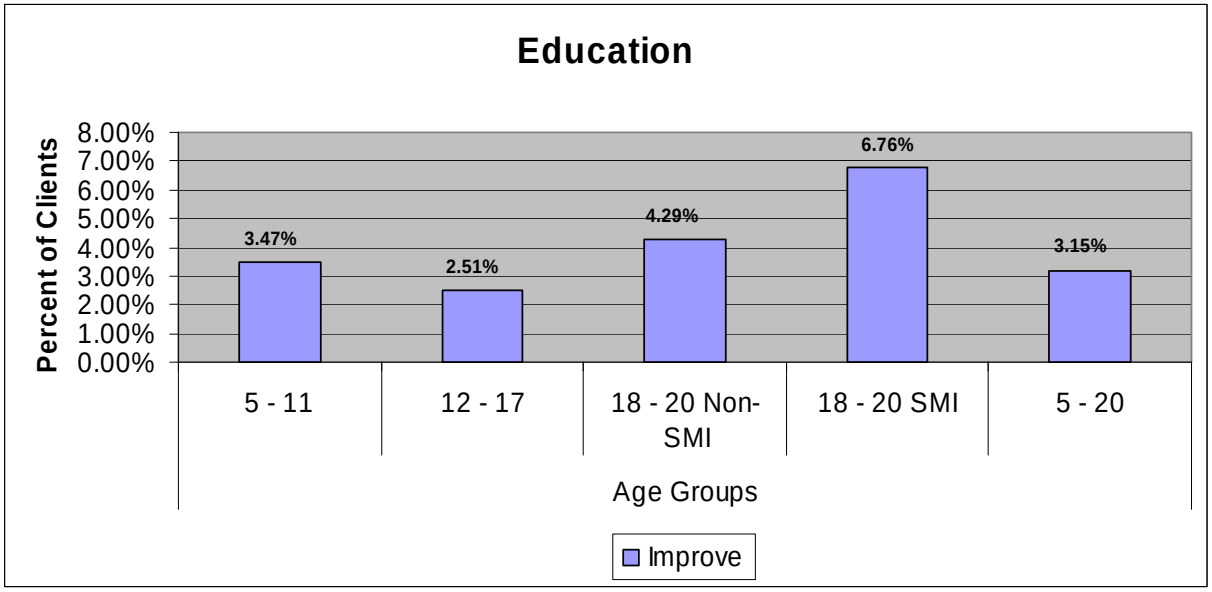
Educational outcomes are measured for the age bands 0-4, 5 – 11, 12 -17, and 18 – 20 both SMI and Non-SMI. Figure M depicts the percentage of recipients involved in school during Q109.

Figure M.



Notable in the Education outcomes is the high rate of school involvement for both the 5 – 11 (92%) and 12 – 17 (95%) age bands.

Figure N.



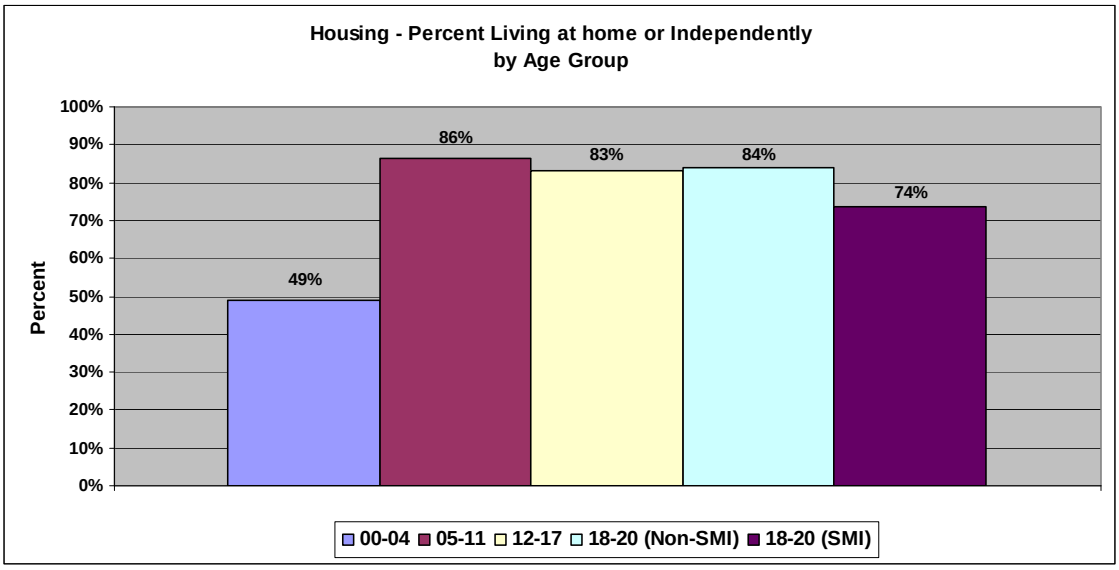
As shown in Figure N, the overall rate of improvement for this measure for all children was 3.15%, meaning that those who were previously not in school, became involved in a school program. The 18-20 year old SMI population demonstrated the most significant improvement in educational status at 6.76% and the 18-20 non-SMI population showed the second highest rate of improvement at 4.29%. A data limitation exists in that the value for education is either "yes" or "no" to the question "school involvement". This results in recipients who have completed schooling being represented as having no school involvement. The lower percentages shown in Figure M for the 18 – 20 age band is a byproduct of this limitation.

Efforts in the PIP described above under employment are also geared toward educational outcomes by increasing psycho educational services and specialized vocational services. These will assist the recipient in being able to move from school to employment, including rehabilitation activities.

Stability in Housing

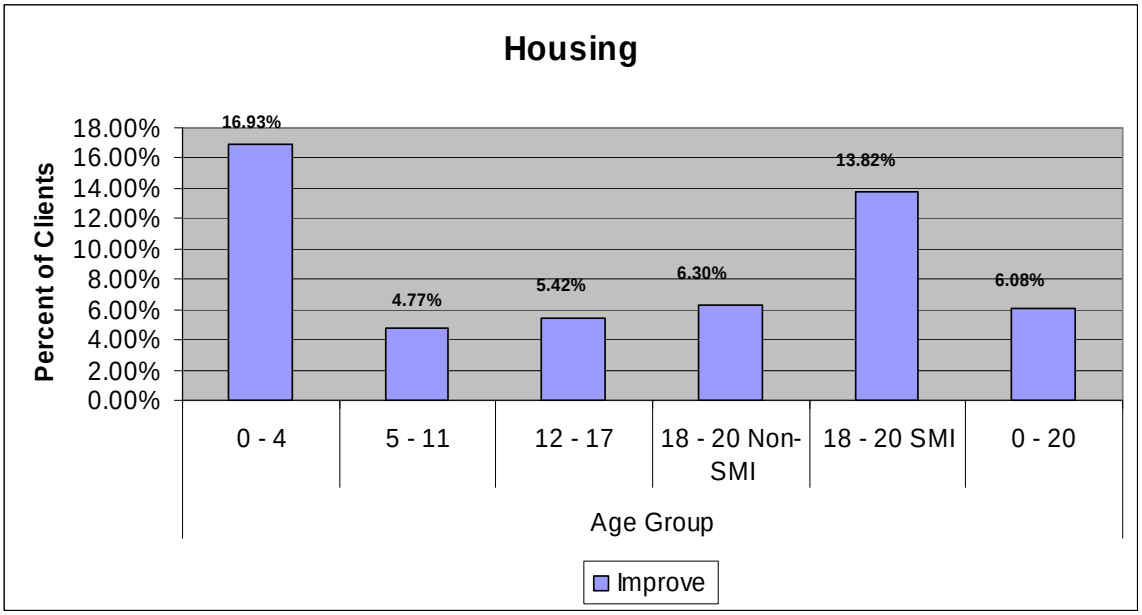
The Stability in Housing outcome is measured through the primary housing demographic field for all age bands. Figure O below represents the percentage of recipients who were living at home with family or independently, with or without a roommate during Q109.

Figure O.



Notable is the 0 – 4 age band at a 49% rate of living at home with family. Although this rate is significantly lower than the other age bands, an improvement in residence for this age group occurred at a rate of 16.93% as seen in Figure P. The low number of children in this age group living at home could be contributed to family involvement with other system partners such as Child Protective Services (CPS). CPS removal data for September shows that this age group accounts for 42.1% of the total removals statewide and 44% of the referrals for the 24-hour urgent response, suggesting that this group is overrepresented in out of home placements. The 0-4 population showed the largest improvement on this measure, with the 18-20 year old SMI population showing the second highest improvement at a rate of 13.82%.

Figure P.



An improvement is noted when the recipient moves from a residential setting; homelessness; institution; or supervisory care setting to living independently, with or without a roommate; at home with family; or any kind of foster home residence. The remaining population not represented in the graph includes those recipients living in a residential facility, institution, foster care, or was homeless.

Table 1 below shows the number of children, as a rate per thousand enrolled, who were in out of home placements during Q109. The statewide rate remained static across the quarter with minimal fluctuation in each GSA, but demonstrates a decrease from Q408 when the rate of out of home placement spiked at 616 children placed out of home at a rate of 18 per thousand TXIX/XXI children enrolled. Overall, this suggests that outcomes related to housing are improving.

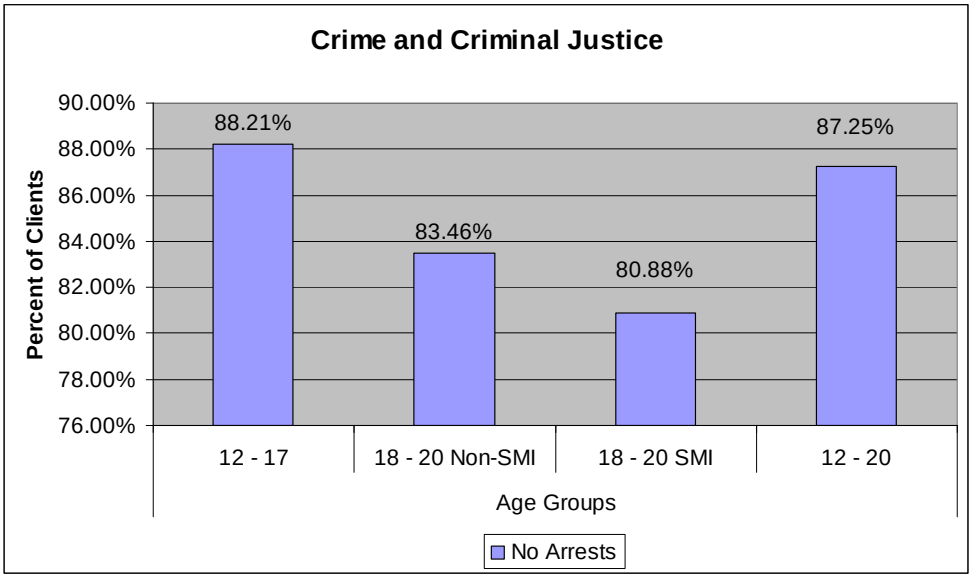
Table 1. Q109 No. of Children in Out of Home Placements, Rate per Thousand Enrolled

	July			August			September		
T/RBHA	TXIX/XXI Enrolmnt	Out of Home	Rate per Thousand	TXIX/XXI Enrolmnt	Out of Home	Rate per Thousand	TXIX/XXI Enrlmnt	Out of Home	Rate per Thousand
CBHS-2	1313	34	**26**	1416	31	**22**	1416	28	**20**
CBHS-4	2889	46	**16**	2873	40	**14**	2873	32	**11**
CPSA-3	1273	8	**6**	1258	8	**6**	1258	12	**10**
CPSA-5	7068	128	**18**	7285	134	**18**	7285	137	**19**
GRIC	615	50	**81**	629	50	**79**	597	49	**82**
Magellan	17589	208	**12**	17774	211	**12**	17774	224	**13**
NARBHA	3826	61	**16**	3902	61	**16**	3902	59	**15**
PYTA	215	23	**107**	221	23	**104**	228	23	**101**
TOTALS	**34788**	**558**	**16**	**35358**	**558**	**16**	**35333**	**564**	**16**

Crime and Criminal Justice

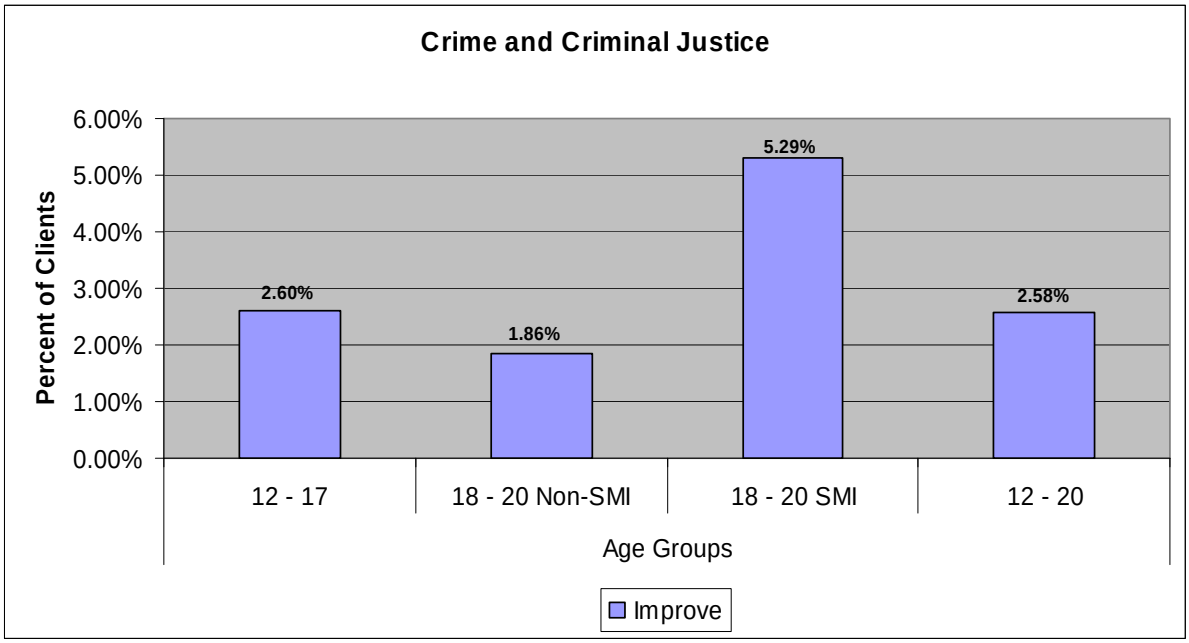
The Crime and Criminal Justice outcome is measured through the number of arrests in the last 30 days prior to the reference point and is represented by the 12 – 17 and 18 – 20 age bands in Figure Q.

Figure Q.



As shown, the overall number of enrolled children age 12 – 20 with no arrests at *both* reference points was at a rate of 87.25%. The remaining population not depicted includes recipients who were arrested at least one time at either reference point. Although, the 18-20 year old SMI group has the lowest rate of no arrests (80.88%), it also shows the highest percentage of improvement in arrest rate at 5.29%. Figure R depicts the overall rate of improvement for each age band on this measure.

Figure R

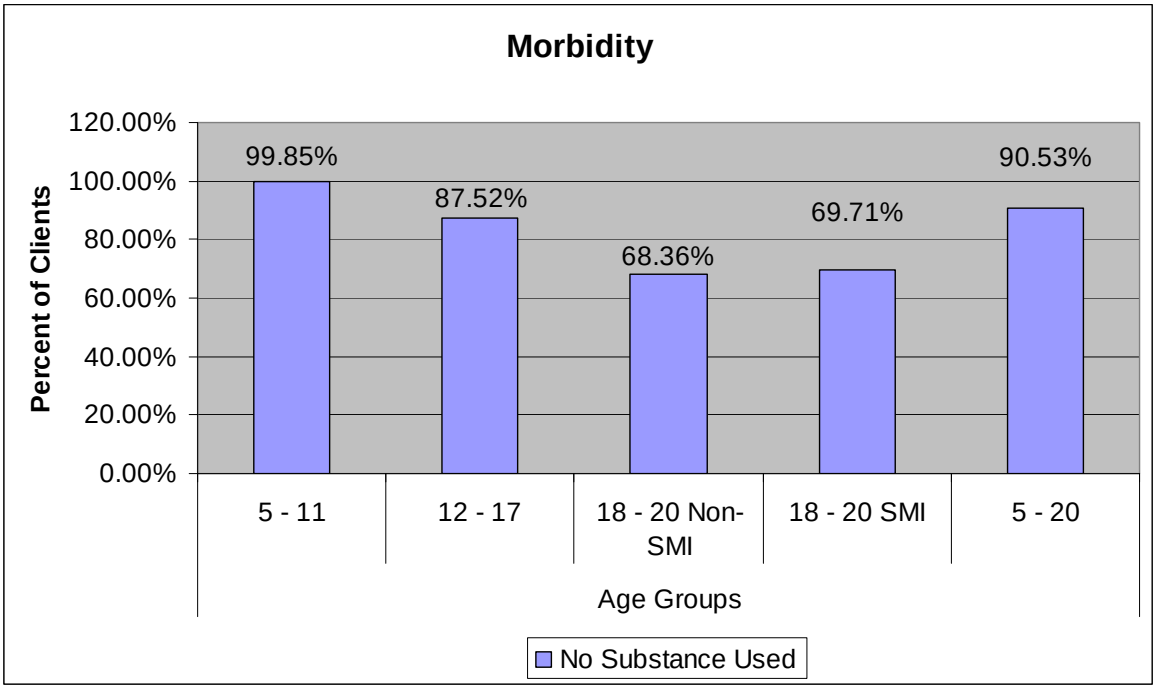


An overall improvement was seen at a rate of 2.58%; the 18 – 20 SMI population had an improvement rate of 5.29%. An improvement in outcomes for crime and criminal justice is defined as a decrease in the number of arrests from the first reference point to the second.

Reduced Morbidity

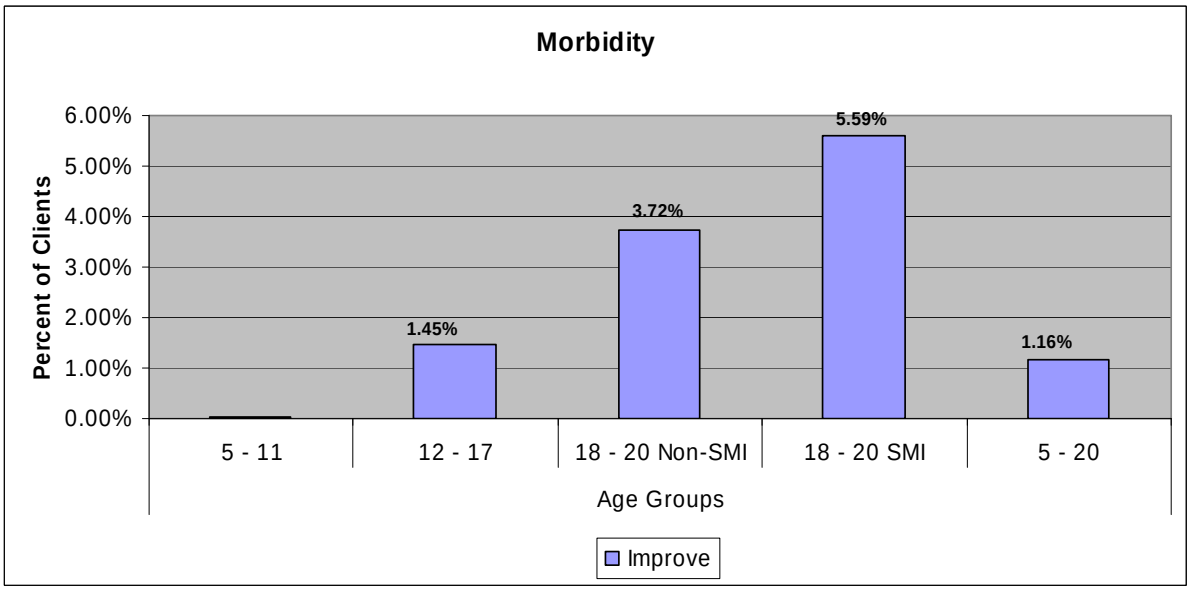
The functional outcome of Reduced Morbidity is measured through the current Primary Psychoactive Substance used 30 days prior to the recipient's reference point (self-report); for recipients who present for treatment after leaving a controlled environment (i.e., jail, prison, or detention) use is reflected as the 30 days prior to incarceration. The applicable age bands are 5 – 11, 12 – 17, and 18 – 20. Outcomes for Reduced Morbidity as represented by zero substance use at both reference points are depicted in Figure S.

Figure S.



The overall rate of recipients who reported no substance use at *both* reference points is 90.53% for all age bands. The remaining population not depicted includes those recipients who reported some substance use at either reference point. Figure T shows the rate of improvement for each age group.

Figure T.



An improvement in morbidity outcomes, as defined by a reduction in substance use from the first reference point to the second, was seen in the 18 – 20 SMI population at a rate of 5.59%, and an overall rate for all age bands of 1.16%. ADHS/DBHS is focused on increasing the improvement rate

for all ages through the expansion of substance abuse programs and program monitoring as described below.

Actions Taken

As mentioned above, Q109 is the first quarter for reporting functional outcomes in this manner. As noted in the data analyses, limitations remain in how the data is reported. Specifically, declines in both employment and education outcomes may be reported when a member graduates school but does not begin an employment activity prior to the second reference point. As such, ADHS/DBHS will review the parameters of the data collection to revise how the outcome data is presented to provide more meaningful analysis in Q209.

To further assess the quality of the substance abuse service delivery system, ADHS/DBHS evaluated Adolescent Intensive Outpatient Programs (IOPs) that provide substance abuse services. This review established a base level of quality for Substance Abuse Programs and offered a better understanding of the various services available to adolescents. Residential substance abuse programs will be evaluated next.

Summary

ADHS/DBHS has established a comprehensive children's system of care that reflects the Arizona Vision and 12 Principles. The ADHS/DBHS Quality Management program collects information from multiple data sources to monitor the quality of the overall system, including interviews with key individuals and in-depth chart reviews. A review of Q109 data compared to trended performance across time provides valuable information from which system improvements have been implemented.

The performance measures and supporting information gleaned from the consumer complaint data provides an overall picture of how the behavioral health system is fairing. Sufficiency of Assessments and Access to Care findings show that the system is performing well with the requirements related to behavioral health recipients entering behavioral health services. Initial appointments are being offered in a timely manner and the initial assessments are sufficient to develop functional treatment recommendations. However, cross analysis of the Appropriateness of Services performance measure, together with the supporting data of Quality of Assessments and Consumer Complaints suggests that as behavioral health recipients remain in the system, difficulties are encountered regarding completing updates to the assessments and providing timely services that are related to the individual service plans. Several actions have been implemented to assist the system in performance improvement in these areas, including:

- substance abuse program monitoring;
- expansion in case management services,
- expansion in support and rehabilitation services,
- expansion in substance abuse services;
- directed technical assistance and;
- performance improvement plans, corrective action plans and sanctions.

Functional outcomes are measured through the collection of several data fields, comparing values at two separate reference points in time. Overall, outcomes for rates of employment, education, living at home or independently, no criminal involvement, and no substance use accounted were positive for the majority of the children's population, with the exception of living at home for the 0 – 4 age group. Improving functional outcomes for all children is a priority for ADHS/DBHS. Improvement efforts include a Performance Improvement Project to increase psycho educational and rehabilitation

services to increase employment; an expansion of support and rehabilitation services, generalist type to increase in-home supports and decrease the need for out of home placements and; an expansion in substance abuse programs (*Attachment G)* and program monitoring. Further efforts will be put forth to revise the parameters and reduce found data limitations so that more meaningful analysis may be completed in Q209.

Quarterly Adult System of Care Report
Q109

This report presents an analysis of statewide performance on the following AHCCCS performance measures: Access to Care, Coordination of Care, Sufficiency of Assessments, and Appropriateness of Services. Performance measures data is trended over multiple reporting quarters and supported by data from existing QM data feeds, including consumer complaints, utilization, Quality of Care (QOC) and grievance and appeals data. The report will focus on performance for the adult population (age >=21) across the ADHS/DBHS system of care.

Reference Document

Arizona Department of Health Services, Division of Behavioral Health Services Performance Improvement Specifications Manual describes the methodologies for the performance measures and supporting data collections (*Attachment A*).

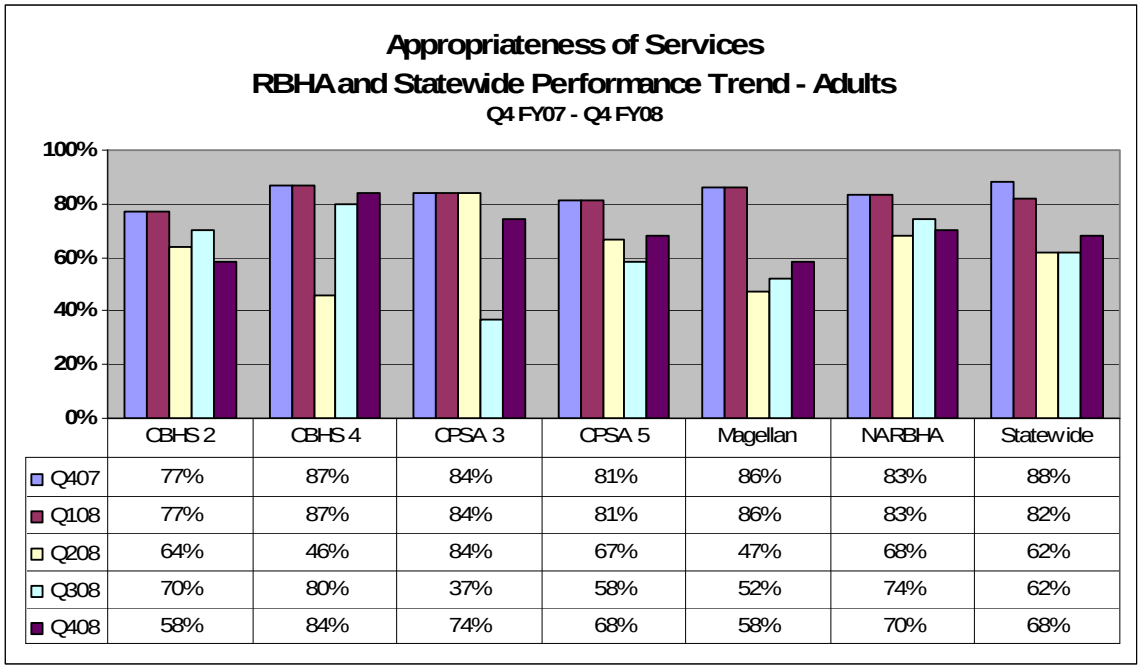
Appropriateness of Services

Appropriateness of Services is assessed through a chart review conducted quarterly by the ADHS/DBHS Office of Monitoring and Oversight to determine if the types and intensity of services, including case management, are provided based on the client's assessment and treatment recommendations. Ten records for each population (SMI, GMH, SA) are randomly selected per Geographic Service Area (GSA). The small sample size is a data limitation for this measure. The minimum performance standard (MPS) for this measure is 85% with a goal of 90% and a benchmark of 95%.

Calculation: $\frac{\text{Number of Charts Reviewed Scored "Yes" on Questions 72, 74 and 75 of Universal Review Tool}}{\text{Total Number of Charts Reviewed}}$

Figure A below shows the results of the reviews trended over FY08. Findings on this measure are reported on a quarter lag due to sampling requirements and the amount of time required by staff to conduct the in-depth review.

Figure A.

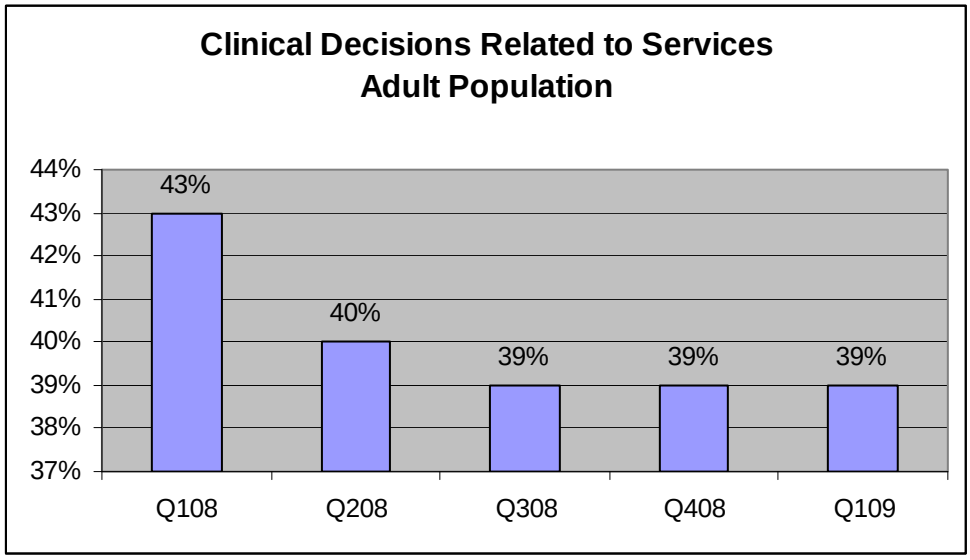


	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q407	77%	87%	84%	81%	86%	83%	88%
Q108	77%	87%	84%	81%	86%	83%	82%
Q208	64%	46%	84%	67%	47%	68%	62%
Q308	70%	80%	37%	58%	52%	74%	62%
Q408	58%	84%	74%	68%	58%	70%	68%

Statewide performance on this measure improved over Q308 scores with a score of 68%. Both CBH AZ 4 and CPSA improved performance this reporting quarter, with CPSA 3 increasing their score by 37 percentage points. Outlier status cannot be applied to any one RBHA, as the majority of Contractors evidence continued noncompliance with the MPS for this measure over the last three reporting quarters. In order to complete a more viable analysis on this measure, ADHS/DBHS QM will review this measure's data by individual data point as well as in the aggregate for a cumulative percentage of compliance beginning in Q209.

A review of consumer complaint data supports the findings of the chart review. The largest numbers of Adult complaints filed by all program types in Q109 were captured in the *Clinical Decisions Related to Services Category*, with a total of 412 complaints, consistent with data reported over FY08 (Figure B).

Figure B.



The sub-category contributing to the *Clinical Decisions Related to Service* complaint numbers is *Assessment/Service Plan Content*, with a total of 178, or 43% of this category's complaints. This subcategory captures complaints pertaining to the types, frequency and intensity of Covered Services provided to the member as outlined in their individual service plan. 30% of *Clinical Decisions Related to Services* complaints fell with in the *Medications* sub-category, capturing complaints pertaining to a member's prescribed medications regime. The Covered Services category most frequently cited in relation to these complaints is *Medication Services*, with 143 *Clinical Decisions Related to Services* complaints (35%). This category received the majority of its complaints from the SMI population. Of the 412 complaints logged in this category, CPSA-5 (51%), CPSA-3 (43%), and NARBHA (35%) contributed the largest number of calls to the complaint total. Both CBHS-2 and CBHS-4 had zero occurrences of complaints in this category, while Magellan reported 16%. CPSA 5 reported the most complaints this reporting quarter, with the majority of CPSA 5 complaints lodged by SMI members, as is consistent with complaint trends reported by this RBHA over FY07 and FY08. CPSA's Member Services Specialists regularly assist SMI members with the lodging and resolution of complaints and this is reflected in the SMI complaint data.

The ADHS/DBHS Office of Grievance and Appeals (OGA) reported data supporting the record review and complaint analysis findings for Magellan, indicating an increase in treatment appeals related to medication denials, housing, and single case agreement denials for the RBHA. This information was provided for Magellan only as Grievance and Appeal reports from other RBHAs did not contain this information. Updates to the RBHA-submitted OGA quarterly reports will enable ADHS/DBHS to compare appeal data for all RBHAs in upcoming quarters.

A review of preliminary Quality of Care (QOC) data analysis indicates that while the total number of QOCs reported by the Greater Arizona RBHAs pertaining to Appropriateness of Services is small, Magellan yielded the 80% of the QOCs (17 total) related to Ineffective/Not Appropriate Treatment. Further review of this information reveals that it pertains specifically to the quality of case management services for recipients with a serious mental illness. This is evident of an ongoing concern with the appropriateness of case management for this population.

Actions taken

The results of performance on this measure were reviewed in the ADHS/DBHS Quality Management Committee and compared to data from various ADHS/DBHS functional areas to determine improvement actions.

The Committee recommended statewide Corrective Action Plans (CAPs) for the Appropriateness of Services Measure. The RBHAs must utilize the Plan, Do, Study, Act (PDSA) Rapid Improvement Model in development of the CAPs, with root cause analysis results evident in reported interventions. The RBHAs must report CAP interim monitoring data to ADHS/DBHS quarterly beginning in Q209. CPSA and Magellan must provide ADHS/DBHS with a complete disposition of the *Clinical Decisions Related to Services/Medications complaints* and monitor for possible Network/capacity implications. Magellan was required to conduct an analysis of its increase in treatment—related appeals to determine potential systems issues. Magellan is also under corrective action related to improving the quality of case management services provided to recipients with a serious mental illness and provides monthly status updates to ADHS/DBHS. Improvement actions include improving competency through training, clinical supervision and a mentoring program for identified case managers.

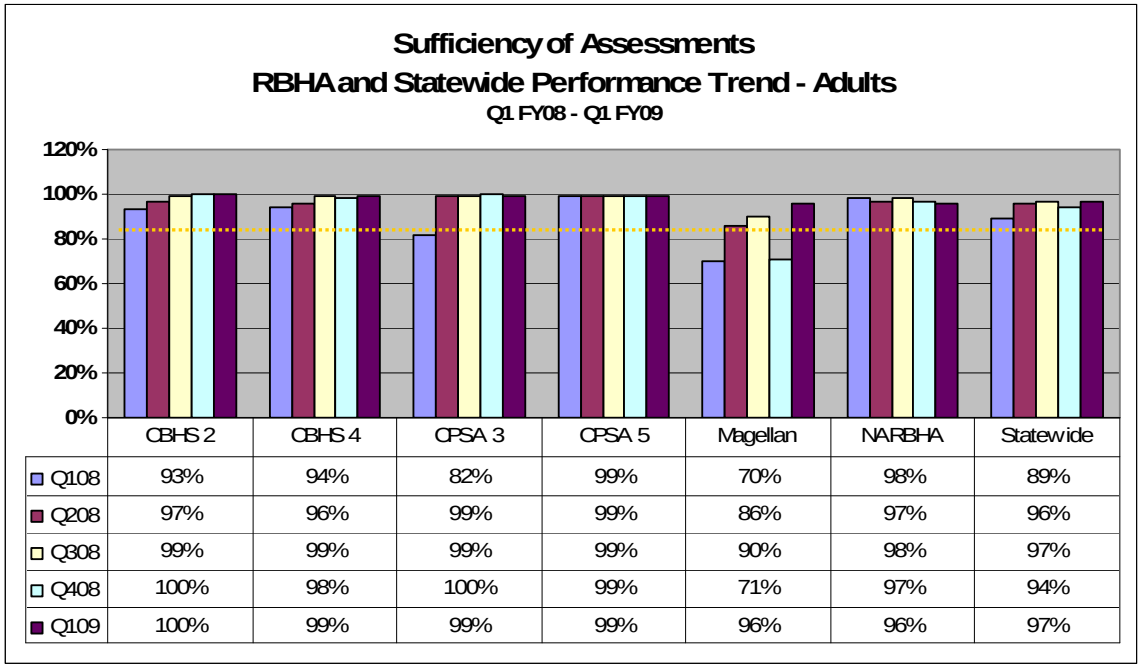
Real time technical assistance is provided to the RBHAs in the Quality Management Coordinators' meetings and includes best practice discussions to drive system wide improvement. In addition, efforts are being made to improve service planning throughout the state with technical assistance provided by ADHS/DBHS Clinical and Network offices.

Sufficiency of Assessments

The Sufficiency of Assessments performance measure evaluates the completeness of the intake assessment to determine if there is sufficient information included to develop functional treatment recommendations. This is measured through the demographic submissions to the Computer Information System (CIS) by counting the number of records that are accepted by the system as complete, meaning that all required assessment fields contain valid values. The MPS for this measure is 85% with a goal of 90% and a benchmark of 95%. Figure C shows the results for the previous year and Q1 of FY09.

Calculation: Number of Accepted Demographic Submissions with completed assessment fields
Total Number of Demographic Submissions to ADHS/DBHS CIS

Figure C.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	93%	94%	82%	99%	70%	98%	89%
Q208	97%	96%	99%	99%	86%	97%	96%
Q308	99%	99%	99%	99%	90%	98%	97%
Q408	100%	98%	100%	99%	71%	97%	94%
Q109	100%	99%	99%	99%	96%	96%	97%

Statewide performance on this measure continues an upward trend from Q108, improving this reporting quarter by 8 percentage points from its baseline measurement. Of note is that Magellan improved its performance score by 25 percentage points this reporting quarter. Magellan is operating under increased technical assistance by ADHS/DBHS to continue improvement in its data submissions, as evidenced in the RBHA's improved Q109 measurement.

Actions Taken

The results of this performance measure are reviewed in the ADHS/DBHS Quality Management Committee, RBHA specific quarterly meetings and in the ADHS/DBHS/RBHA Quality Management Coordinators' meetings. As the RBHAs are all exceeding the goal and benchmark on the Sufficiency of Assessments standard, no corrective actions are required.

Coordination of Care

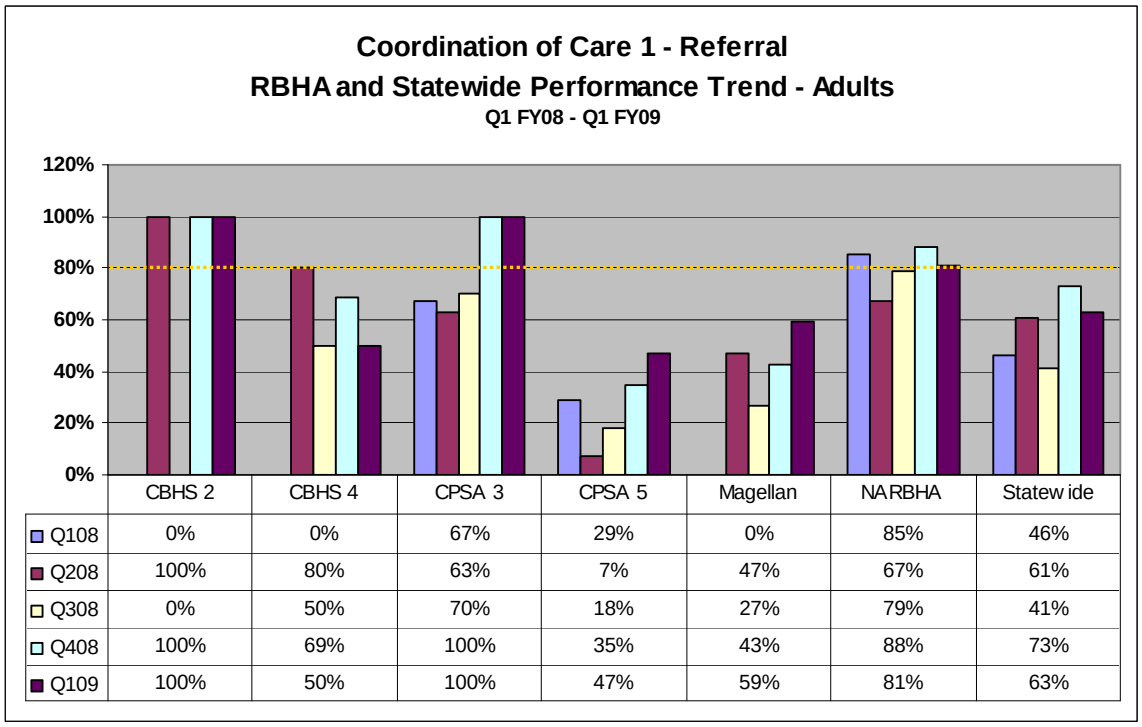
Coordination of Care (COC) looks at two standards to assess compliance with coordinating behavioral health services with the member's Primary Care Physician (PCP)/Health Plan.

COC 1 (Referral)

COC 1 reviews cases of behavioral health recipients referred by the PCP/ Health Plan to determine if the RBHA communicated the disposition of the referral back to the referral source within the required timeframes (See attached ADHS/DBHS Performance Improvement Specifications Manual). The MPS for this measure is 80%, with a goal of 90% and a benchmark of 95%. Figure D shows the trends across the last five review quarters. A limitation of this data is that the 'n' size may be small as it is dependent on the number of individuals referred by the PCP or Health Plan for the reporting period.

Calculation: Number of Charts Containing Referral Disposition Documentation
Total Number of Charts Reviewed

Figure D.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	0%	0%	67%	29%	0%	85%	46%
Q208	100%	80%	63%	7%	47%	67%	61%
Q308	0%	50%	70%	18%	27%	79%	41%
Q408	100%	69%	100%	35%	43%	88%	73%
Q109	100%	50%	100%	47%	59%	81%	63%

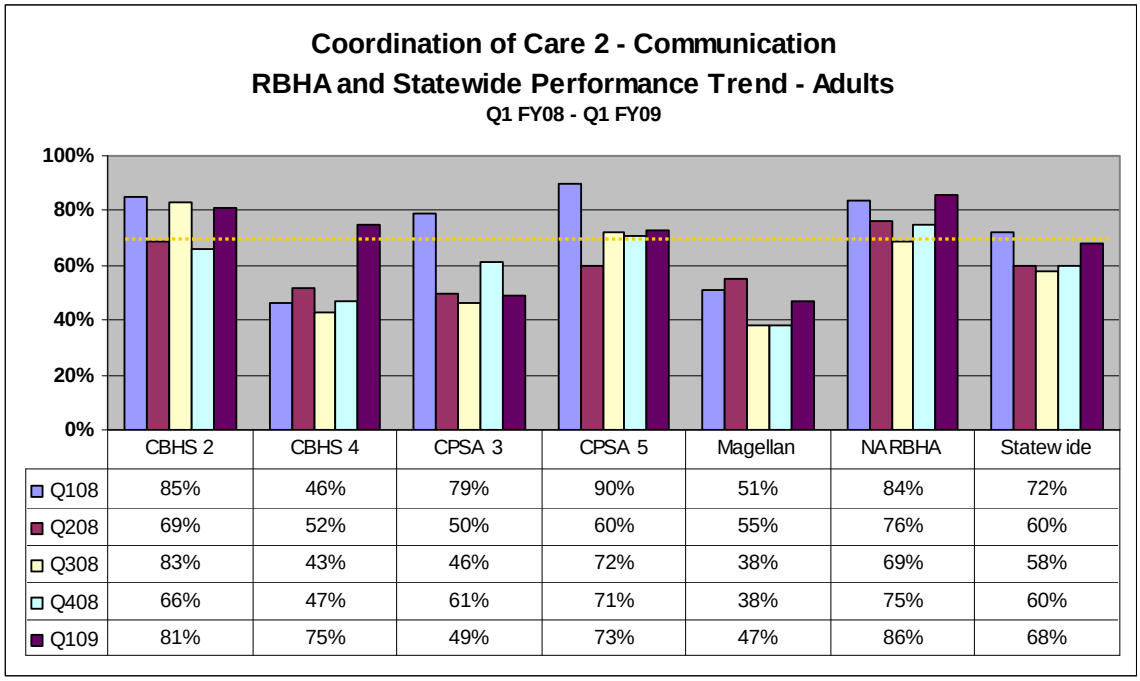
Statewide performance in Q109 dropped 10 percentage points from Q408 but remained reflective of the distribution of scores across FY08 for this measure. While all RBHAs demonstrate ongoing improvement opportunities on COC 1, CPSA 5 and Magellan consistently negatively impact the overall statewide score on this measure. CBHS 2, CPSA 3 and NARBHA met or exceeded the MPS this reporting quarter, with CBHS 2 and CPSA 3 surpassing the benchmark. It should be noted that CBHS 2&4 and CPSA 3 have 'n' sizes of 6, 4 and 2, respectively, therefore the data should be interpreted with caution.

COC 2 (Communication)

COC 2 assesses ongoing communication with the PCP for behavioral health recipients with SMI and/or a chronic medical condition on Axis III. The MPS is 70%, with a goal of 80% and a benchmark of 90%. Figure E shows the trends across FY08 to Q109.

Calculation: Number of Charts Containing Documented COC Attempts with PCP
Total Number of Charts Reviewed

Figure E.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	85%	46%	79%	90%	51%	84%	72%
Q208	69%	52%	50%	60%	55%	76%	60%
Q308	83%	43%	46%	72%	38%	69%	58%
Q408	66%	47%	61%	71%	38%	75%	60%
Q109	81%	75%	49%	73%	47%	86%	68%

Although the MPS was not met statewide in Q109, performance on this measure continues an upward trend, improving from the lowest data point (Q308) by 10 percentage points. Magellan has yet to meet the MPS for COC 2, although the remaining RBHAs, with the exception of CPSA-3, met the minimum standard for Q109.

Combined Analysis

Coordination with behavioral health recipients' PCP/ Health Plan requires continued improvement efforts. Only 2 RBHAs, CBHS-2 and NARBHA, achieved above the MPS on both measures for Q109. Complaint data over the last three reporting quarters do not support the findings of the COC measure, as this complaint category continues a downward trend, no longer impacting the top three complaint categories (see attached). Preliminary QOC data indicates only 5 total COC related concerns, all of which are attributed to Magellan.

Barriers to compliance on both measures include documentation issues, including the lack of or no documentation of the coordination with the PCP; the documentation of attempts are not timely; the documentation is not clearly identifiable as a coordination of care attempt (e.g.,

variation in how the attempt is documented) and; the direct service providers often are uninformed as to the members' PCP assignment. In addition, there is a need for increased RBHA oversight of the direct service/Network sites' processing of referrals and monitoring of ongoing PCP/Health Plan communication attempts per changes in the members' health status.

Actions Taken

All the RBHAs are under a CAP due to poor performance on this measure. Interim monitoring of CAP implementation is reported quarterly and evaluated by the ADHS/DBHS QM Committee and Compliance Office. The ADHS/DBHS QM Committee recommended increased sanctions for RBHAs not meeting the MPS for the COC measure again this reporting quarter (Magellan, CBHS-4, CPSA-3, CPSA-5). This recommendation will be forwarded to the Sanction Committee for approval.

Technical assistance is routinely provided on this measure in the RBHA QM Coordinators' Meeting, including review and clarification of documentation requirements, the timeframes for reporting disposition of referral, indicators for ongoing PCP/Health Plan communications and calculation of RBHA referral log errors.

Access to Care

Access to Care consists of two measures evaluating compliance to the required timeframes for providing services after referral.

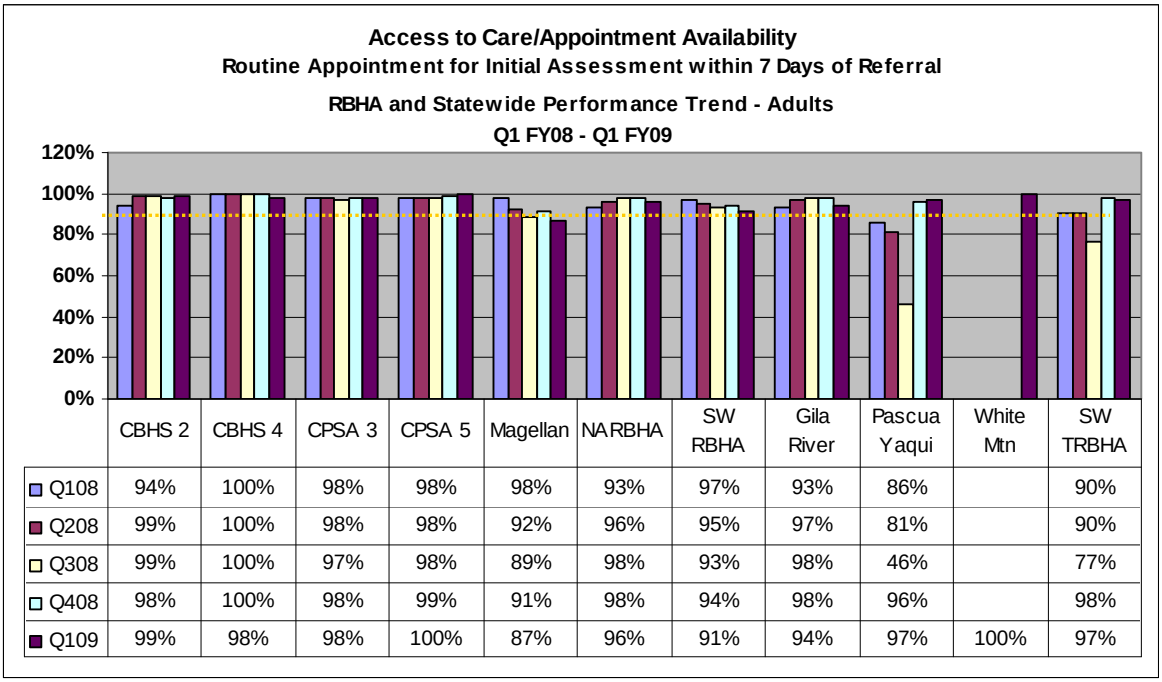
7 Day Measure

The 7-day measure looks at the number of days between the referral date and the first appointment offered to ensure that it occurs within the required 7 days.

Calculation: Number of Referrals with <=7 days from Referral Date to First Appointment Offered Date
Total Number of Referrals Submitted by T/RBHA
= Percent in Compliance

The MPS is 85%, with a goal of 90% and a benchmark or 95%. Figure F shows the trends of this measure across the past 4 quarters and includes information on the Tribal Regions in addition to the GSAs. This is the first quarter for collecting information on White Mountain Apache Behavioral Health; trending will begin from this point forward.

Figure F.



	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	SW RBHA	Gila River	Pascua Yaqui	White Mtn	SW TRBHA
Q108	94%	100%	98%	98%	98%	93%	97%	93%	86%		90%
Q208	99%	100%	98%	98%	92%	96%	95%	97%	81%		90%
Q308	99%	100%	97%	98%	89%	98%	93%	98%	46%		77%
Q408	98%	100%	98%	99%	91%	98%	94%	98%	96%		98%
Q109	99%	98%	98%	100%	87%	96%	91%	94%	97%	100%	97%

All RBHAs scored above the MPS of 85% and, with the exception of Magellan (87%), above the benchmark of 95%. Statewide RBHA performance for the Adult population was 91%. Gila River scored 94%, White Mountain Apache 100%, and Pascua Yaqui, for the first two months of the quarter, 97%, for a statewide TRBHA score of 97%. It should be noted that Pascua Yaqui is currently unable to pull September data from its client information system, ClaimTrack. The tribe is attempting to resolve the issue through technical assistance from ClaimTrack but as of this writing is unable to provide ADHS/DBHS with an estimate of when data will be available. Pascua Yaqui's performance for Q109 will be stated in ADHS/DBHS' Q209 report.

23 Day Measure

The 23-day measure looks at the number of days between the initial assessment and the first provided service to ensure that it occurs within the required 23 days.

Calculation:

Number of behavioral health recipients with an intake during the quarter and a corresponding assessment encounter within 45 days of the intake date and with an ongoing service encounter within 23 days after the assessment

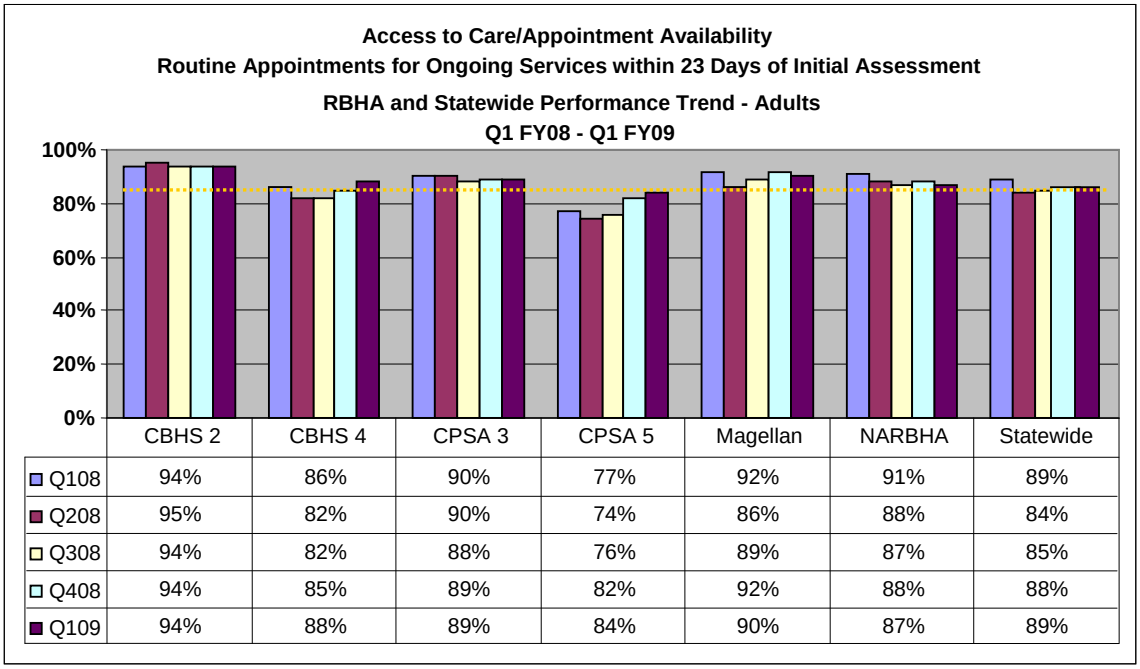
---

Total number of behavioral health recipients with an intake during the quarter and a corresponding assessment encounter within 45 days of the intake date ("usable" intakes)

= Percent in Compliance

The MPS is 85%, with a goal of 90% and a benchmark or 95%. Figure G shows the trends of this measure across the past 4 quarters.

Figure G.

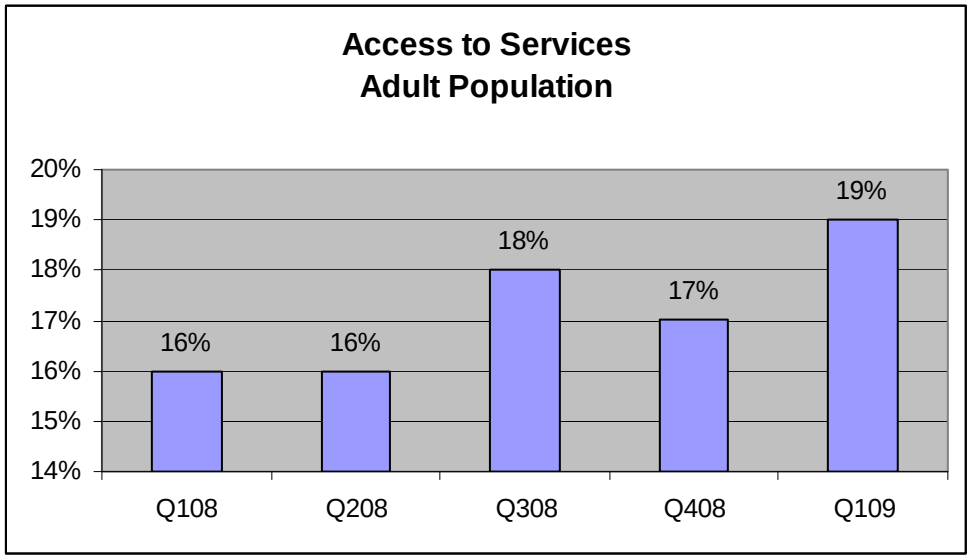


	CBHS 2	CBHS 4	CPSA 3	CPSA 5	Magellan	NARBHA	Statewide
Q108	94%	86%	90%	77%	92%	91%	89%
Q208	95%	82%	90%	74%	86%	88%	84%
Q308	94%	82%	88%	76%	89%	87%	85%
Q408	94%	85%	89%	82%	92%	88%	88%
Q109	94%	88%	89%	84%	90%	87%	89%

Statewide performance exceeded the MPS of 85% at 89%, with all RBHAs exceeding the 85% requirement except CPSA 5 at 84.3%. Performance suggests that RBHAs are consistently providing a first service within 23 days of the initial assessment.

While the findings on both measures show acceptable statewide performance in Access to Care, an analysis of complaint data consistently has found the *Access to Services* category among the top 3 highest complaints (Figure H), with a total of 204 complaints in Q109.

Figure H.



The sub-category contributing to the overall complaint rate for *Access to Services* is *No Provider to Meet Needs*, at 37%, or 76 complaints. This sub-category captures complaints pertaining to a member's concern that a certain provider type is not available to them for a covered service. *Timeliness* was the second highest sub-category for *Access to Services*, with 63 (31%) of this category's complaints. This sub-category captures member complaints pertaining to services being provided in a timely manner. The most frequently cited Covered Services Category related to *Access to Services* complaints is *Medication Services*. The GMH population lodged 43%, or 102, total *Access to Services* complaints this reporting quarter.

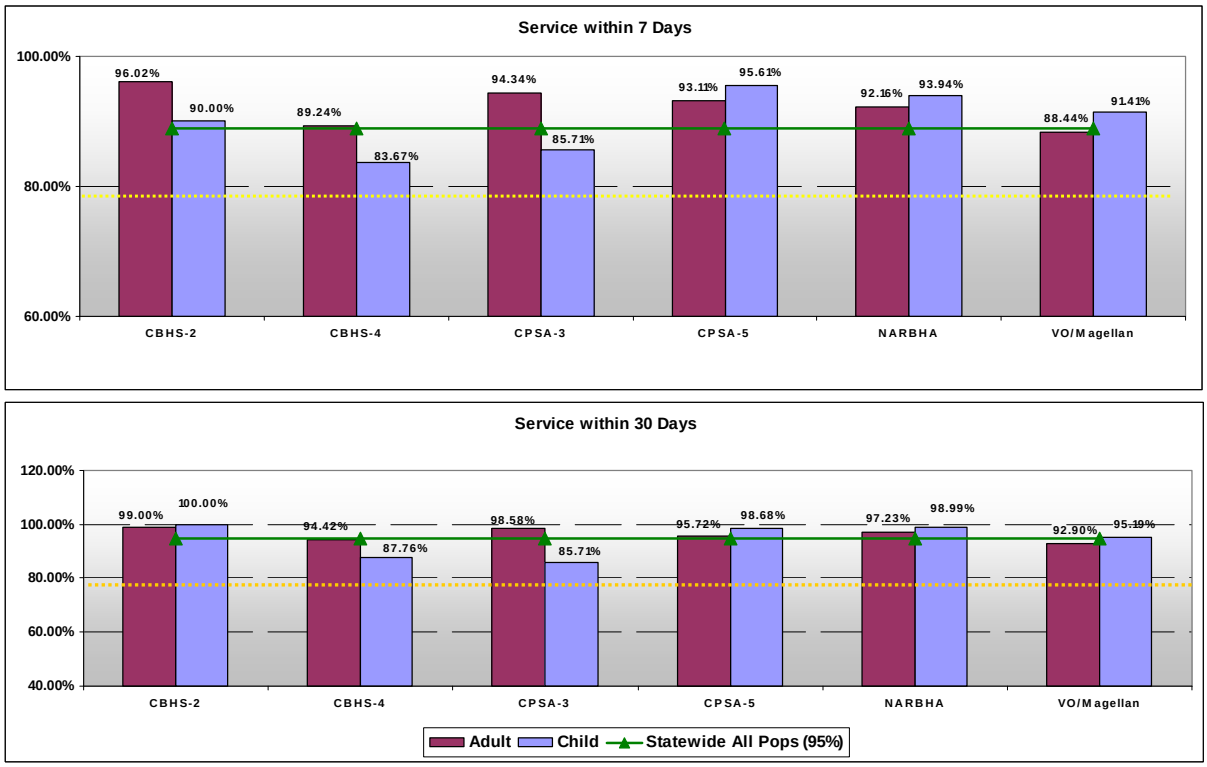
Magellan and CPSA 5 indicated an increase in GMH complaints in this complaint category in Q109. Magellan is monitoring this population's complaints for identification of further system issues and working with its GMH providers to improve member care. Magellan reports quarterly to ADHS/DBHS on Psychiatric Recovery Center (PRC)/Urgent Psychiatric Care West (UPC West) utilization by its members for the purposes of obtaining medications including a Prescriber sufficiency analysis. The Q408 report indicated the GMH population utilizes these services for this purpose more frequently than the SMI population. The correlation to the complaint data indicates that GMH members may experience barriers in accessing timely medication services in this RBHA. ADHS/DBHS required Magellan to report the status of improvement efforts targeted to this population quarterly for ongoing evaluation and monitoring. ADHS/DBHS presented this data to the QM Committee as an indicator of a potential Network issue.

CPSA attributed the increase in this category's complaints for all populations to Network sufficiency issues, i.e. support staff retention, and lack of knowledge of Network providers in newly hired staff. ADHS/DBHS is requiring CPSA to conduct a second level review of the disposition of these complaints and report improvement activities targeting the GMH population, staff retention and education provided to Network staff quarterly.

ADHS/DBHS reviews the Follow-up Service after Discharge standard as proxy measurement to the Access to Care measure. This standard assesses compliance with providing a behavioral health service to a member within the required timeframes (7 days and 30 days) following a discharge from a Level 1 Inpatient Setting. Calculation of this standard utilizes encounter data and is reported on a lag to allow for encounter submission. The MPS is 79% and was met or

surpassed by all RBHAs in Q408 as shown in Figure I. Comparing data from this standard to Complaint trends and the Access to Care performance measure suggests that while the RBHAs are meeting requirements related to offering services to members utilizing higher level services in a timely fashion, routine appointments for ongoing services to enrolled members, including accessibility to specialty providers and Prescriber capacity, may be negatively impacting the system.

Figure I.



Actions Taken

CPSA 5 must develop a CAP to address not meeting the minimum performance standard on the Access to Care 23 day measure and must include a root cause analysis of their previous CAP addressing ongoing performance issues and including new interventions to drive improvement. Ongoing monitoring of CPSA's progress will occur through the ADHS/DBHS QM Committee.

ADHS/DBHS provides technical support to the RBHAs, including the initiation this reporting quarter of providing the source data pulled from the ADHS/DBHS CIS that is used to calculate the Access to Care 23 Day Measure. The data includes client identifying information, assessment dates, and dates ongoing services were provided per encounters submitted to CIS.

As reported above, CPSA and Magellan will provide ADHS/DBHS with root cause analyses and improvement efforts targeting the GMH population and the access of timely covered services.

After a review of data in the ADHS/DBHS Utilization Management Committee, it was decided to increase the MPS on the Follow-up Services after Discharge standard to 90% for the 7-day measure and 95% for the 30-day measure.

Summary

Q109 Performance Measures analysis indicates system wide areas for improvement based on trends from multiple data feeds as evaluated over five reporting quarters. Data supports the finding that the ADHS/DBHS system of care ensures that persons entering into behavioral health services receive initial assessment appointments in a timely fashion and the assessment conducted at the initial appointment is sufficient in the development of functional treatment recommendations. Areas for improvement are evident when cross walking the Access to Services and Sufficiency of Assessments data with Complaint and QOC information. This supporting data indicates system deficiencies in ongoing assessment, coordination of services and the timely provision of covered services to members remaining in behavioral health services. Improvement activities focus on Coordination of Care, Access to Care and service planning. Evaluation of the GMH population's medication utilization patterns and access to Prescribers will be monitored by ADHS/DBHS to assess for possible Network Sufficiency implications.

Performance data reviewed by the ADHS/DBHS QM Committee is presented to the RBHAs via email, letter and discussed as part of the RBHA QM Coordinators' Meetings. The RBHAs currently conduct performance improvement activities utilizing performance measures data. Each RBHA reports interim monitoring data for open PI Plans and CAPs to ADHS/DBHS at least quarterly.

CBH AZ conducts quarterly chart reviews of its providers and provides real time training and technical assistance in its network through provider meetings and mentoring. The RBHA applies CAPs to providers not meeting the MPS on ADHS/DBHS performance measures, up to and including sanctions.

CPSA conducts monthly Quality Management Liaison monitoring at each of its Network service sites in order to profile its providers and provide viable technical assistance, both onsite and quarterly in Network specific Collaborative Technical Assistance Meetings (CTAs). Corrective actions are applied to Networks not meeting performance standards with targeted training and interventions initiated in response to performance data.

NARBHA conducts twice yearly reviews of its Networks and incorporates performance measure and complaint data into its oversight and monitoring of providers. Providers not meeting the MPS for both ADHS/DBHS and NARBHA performance indicators receive training, Letters of Concern, CAPs, or sanctions.

Magellan conducts ongoing provider monitoring and focused reviews of providers based on performance data. Providers and direct service sites not meeting minimum performance standards are targeted for training, technical assistance and receive corrective action.

ADHS/DBHS QM assesses and evaluates RBHA specific improvement activities in conjunction with multiple data feeds within the Division. Systemic trends identified from QM data is shared with representatives from each functional area within ADHS/DBHS in the QM Committee Meetings and sub-committees to ensure performance data is utilized to drive improvements within the Division.

Attachment A

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

PERFORMANCE IMPROVEMENT SPECIFICATIONS MANUAL

Revision Date: November 2008

Table of Contents

I. CIS ENROLLMENT AND PENETRATION PROTOCOL
   a. Enrollment/Penetration Protocol 1
   b. Attachment A 7

II. ENROLLMENT PENETRATION FOR SPECIAL POPULATIONS – Under Development 9/2008 8

III. PERFORMANCE MEASURE INCENTIVES 9

IV. ANNUAL MHSIP CONSUMER SATISFACTION SURVEY PERFORMANCE MEASURES 11

V. APPROPRIATENESS OF SERVICES 16

VI. SUFFICIENCY OF ASSESSMENTS 18

VII. QUALITY OF ASSESSMENTS 20

VIII. COORDINATION OF CARE 22

IX. APPOINTMENT AVAILABILITY FOR INITIAL ASSESSMENT
   a. Specification 25
   b. Attachment A 28

X. ROUTINE APPOINTMENT FOR ONGOING SERVICES WITHIN 23 DAYS OF INITIAL ASSESSMENT (ASSESSMENT TO FIRST SERVICE)
   a. Specification 29
   b. Attachment A 33
   c. Attachment B 45

XI. COMPLAINT REPORTING
   a. Specification 46
   b. Attachment A 48

XII. FOLLOW UP SERVICES AFTER DISCHARGE FROM A FACILITY
   a. Specification 49
   b. Attachment A 51

XIII. AVERAGE LENGTH OF STAY 52

XIV. READMISSION RATE 54

XV. SHOWING REPORT
a. Specification 56
b. Showing Report Checklist 58

XVI. INCIDENT/ACCIDENT/DEATH TRENDING REPORT AND
a. SECLUSION AND RESTRAINT REPORTING 59

XVII. MORTALITY REVIEW FORM AND MORTALITY ADDENDUM 63

XVIII. CHILDREN'S SYSTEM OF CARE STRUCTURAL ELEMENTS
a. Specification 68
b. Attachment A 70

XIX. PHARMACY REPORT
a. Specification 71
b. Attachment A 72

XX. SUBSTANCE USE DISORDER AND CO-OCCURRING DISORDERS 73

XXI. ELECTRONIC QUALITY MANAGEMENT REPORT TEMPLATE - PRINT SCREEN 75

XXII. ELECTRONIC UM REPORT TEMPLATE - PRINT SCREEN 76

XXIII. ADHS/DBHS UNIVERSAL RECORD REVIEW TOOL – PRINT SCREEN . 77

ENROLLMENT - PENETRATION PROTOCOL

DESCRIPTION

A. PURPOSE:

To maintain a consistent method of identifying how many people have been served in the behavioral health system and the rate in which the system is meeting the needs of the community.

METHODOLOGY

B. DEFINITIONS:

Behavioral Health Category: This is determined by the most current value within the Behavioral Health Category Code field in the Demographic Snapshot. However, the following age sub-definitions apply as determined by the behavioral health recipient's age at the end date of reference:

- Child (Child) – Age must be 0 to less than 18
- Serious Mentally Ill (SMI) – Age must be 18 or greater
- Substance Abuse (SA) – Age must be 18 or greater
- General Mental Health (GMH) – Age must be 18 or greater
- Children's Medical Dental Plan (CMDP) – Age must be 0 to less than 18

Closed Eligibility Segment: An AHCCCS Eligibility record with a start date prior to or the same as the end date of reference and an end date after or the same as the start date of reference.

Closed Enrollment Segment: An enrollment segment with a start date prior to or the same as the end date of reference and an end date after or the same as the start date of reference.

Eligibility Category: This is determined by the value within the Contract Type field in the AHCCCS Eligibility Snapshot. If there was an eligibility segment at any time during the dates of reference, then the segment is selected. In order to determine CMDP Eligibility, the Contract Type value of "7" is used from the AHCCCS At Risk Snapshot. CMDP eligibility supersedes any other eligibility category for behavioral health recipients who are less than 18 years of age.

Enrollment: The count of unduplicated behavioral health recipients who had an intake record at any time during the dates of reference.

Open Eligibility Segment: This is an AHCCCS Eligibility record with a null value in the end date field and a start date prior to or the same as the end date of reference.
Open Enrollment Segment: This is an enrollment segment with a null value in the enrollment closure field and an intake date prior to or the same as the end date of reference.

Penetration: The rate by which the number of Medicaid eligible consumers, as determined by AHCCCS, have been enrolled in the behavioral health system during the dates of reference (*Enrollment ÷ Eligible*).

Snapshot: This refers to a table created from the "live production" data as of a single point in time.

C. ENROLLMENT PROCEDURES:

1. Go to the most current Intake Table Snapshot, extract all intakes that have a valid intake date that is prior to or the same as the end date of reference and a closure date that is null (open segment) or after or the same as the start date of reference.
2. Join this extraction of all intakes from C1 to the most current Closure Table Snapshot. Define join using Contr_ID, Client_ID, and Intake Date.
3. From C2, extract enrollment records using the following Enrollment Closure hierarchy:
    i. Event Date from the Closure Table Snapshot where a valid Event Date is greater than or equal to the start date of reference. Assign Enrollment Closure Date = Closure.Event_Date
    ii. If there is no matching record in the Closure Table, then use the Closure Date from the Intake Table Snapshot where a valid Closure Date is greater than or equal to the start date of reference or is Null (blank). Assign Enrollment Closure Date = Intake.Closure_Date (if Intake.Closure_Date is Null, then substitute it with the end date of reference).
4. These are all potential enrollment segments. Join the enrollment segments from C3 to the CIS Primary Client Snapshot to define all enrollments under the Primary Client ID.

    Find all Primary Client IDs by defining the join as Enrollment.Client_ID = CISPrimaryID.Client_ID.
    Primary Client ID = CISPrimaryID.Primary_Client_ID
    Secondary Client ID = Enrollment.Client_ID
    If there is no matching CISPrimaryID record then,
    Primary Client ID = Enrollment.Client_ID
    Secondary Client ID = Enrollment.Client_ID
5. From extract C4, remove Dummy CIS Client IDs. Define join to Dummy Client ID Snapshot using Client_ID and Contr_ID.
6. From extract C5, select the most current enrollment segment based on the Primary Client ID. Define the most current Enrollment segment using the following hierarchy:

i. Open enrollment segment
ii. If there are only closed enrollment segments, select the closed segment with the maximum Enrollment Closure.
iii. If there is more than one segment that meets criteria C6i or C6ii, next refer to the segment with the maximum CIS Add Date.
iv. If there is more than one segment that meets criteria C6iii, next refer to the segment with the maximum Intake Date.
v. If there is more than one segment that meets criteria C6iv, next refer to the segment with the maximum Change Control Date.

D. ELIGIBILITY CATEGORY PROCEDURES:

1. Join the Client Demographic Snapshot to the Primary Client ID Snapshot to define each Demographic record under the Primary CIS Client ID.

Find all Primary Client IDs by defining the join as Demographic.Client_ID = CISPrimaryID.Client_ID.
Primary Client ID = CISPrimaryID.Primary_Client_ID
Secondary Client ID = Demographic.Client_ID
If there is no matching CISPrimaryID record then,
Primary Client ID = Demographic.Client_ID
Secondary Client ID = Demographic.Client_ID

2. Join extract D1 with the most current Enrollment C6 based on Client_ID, Contr_ID, and Intake_Date. If multiple demographics exist in extract D2, select the most current Demographic record for each behavioral health recipient based on the Primary Client ID. Define the most current Demographic record using the Primary Client ID and the following hierarchy:

i. Maximum Demographic Intake Date
ii. If there is more than one segment that meets criteria D2i, next refer to the segment with the maximum CIS Add Date.
iii. If there is more than one segment that meets criteria D2ii, next refer to the segment with the maximum Change Control Date.
iv. If there is more than one segment that meets criteria D2iii, next refer to the segment with the maximum Transaction Code.

3. Join the AHCCCS Eligibility Snapshot to the AHCCCS ID Crosswalk Snapshot to find all Eligibility segments associated with the same behavioral health recipient using the Primary AHCCCS ID. Select the Eligibility segments that have a valid Start Date prior to or the same as the end date of reference and (a valid End Date that is after or the same as the start date of reference or End Date is null).

Find all Primary AHCCCS IDs by defining the join as Eligibility.AHCCCS_ID = Crosswalk.Old_AHCCCS_ID.
Primary AHCCCS ID = Crosswalk.New_AHCCCS_ID
Secondary AHCCCS ID = Eligibility.AHCCCS_ID
If there is no matching Crosswalk record then,
Primary AHCCCS ID = Eligibility.AHCCCS_ID
Secondary AHCCCS ID = Eligibility.AHCCCS_ID

4. Join extract from D3 to the Primary Client ID Snapshot to define each Eligibility segment under the Primary CIS Client ID.

Find all Primary Client IDs by defining the join as Eligibility.Client_ID = CISPrimaryID.Client_ID.

Primary Client ID = CISPrimaryID.Primary_Client_ID
Secondary Client ID = Eligibility.Client_ID

If there is no matching CISPrimaryID record then,

Primary Client ID = Eligibility.Client_ID
Secondary Client ID = Eligibility.Client_ID

5. From extract D4, select the most current Eligibility segment for each behavioral health recipient based on the Primary Client ID. Define the most current Eligibility segment using the Primary Client ID and the following hierarchy:

i. Open eligibility segment
ii. If there are only closed eligibility segments, select the closed segment with the maximum End Date.
iii. If there is more than one segment that meets criteria D6i or D6ii, next refer to the segment with the maximum CIS Add Date.
iv. If there is more than one segment that meets criteria D6iii, next refer to the segment with the maximum Start Date.
v. If there is more than one segment that meets criteria D6iv, next refer to the segment with the maximum Change Control Date.

6. Join the AHCCCS At Risk snapshot to the AHCCCS SSN Crosswalk snapshot to find all CMDP At Risk segments associated with the same behavioral health recipient using the Primary AHCCCS ID.

Find all segments under the old AHCCCS ID by defining the join as AtRisk.AHCCCS_ID = Crosswalk.Old_AHCCCS_ID.

Primary AHCCCS ID = Crosswalk.New_AHCCCS_ID
Secondary AHCCCS ID = AtRisk.AHCCCS_ID

If there is no matching Crosswalk record then,

Primary AHCCCS ID = AtRisk.AHCCCS_ID
Secondary AHCCCS ID = AtRisk.AHCCCS_ID

7. Join the most current AHCCCS Eligibility segment D5 with the At Risk extract D6 using the Primary AHCCCS ID field from both extracts. Obtain the Primary Client ID from the most current Eligibility segment D5.

8. Since the AHCCCS Eligibility table can have multiple Client IDs for each AHCCCS ID, only the most recent Client ID needs to be associated to each At Risk record. Join the At Risk extract D7 with the most current Enrollment C6 using the Primary Client ID.

9. Select the At Risk record that has an associated enrollment record based on the Primary Client ID.

10. Join all main extracts into one enrollment table based on the Primary Client ID.

Main Intake/Closure Extract (C6)
Main Demographic Extract (D2)
Main AHCCCS Eligibility Extract (D5)
Main At Risk Extract (D9)

11. Assign each Enrollment segment a new Behavioral Health Category (QM_BHC) and a new Eligibility Group (QM_ELIG) using the following "If-Then-Else" logic:

If At Risk Contract_Type = “7” and QM_AGE < 18 then
QM_BHC = “CMDP” and
QM_ELIG = “T19-CMDP”
Else if At Risk Contract_Type = “7” and QM_AGE >= 18 then
QM_ELIG = “T19”
Else
If Eligibility ELG_GRP = “T19” or “DD” or “SDI” then QM_ELIG = “T19”
If Eligibility ELG_GRP = “T21” or “HI” then QM_ELIG = “T21”
If Eligibility ELG_GRP = Null (blank) then evaluate Eligibility Contract_Type as follows:
If Eligibility Contract_Type = “K” or “S” then QM_ELIG = “T19”
If Eligibility Contract_Type = “V” then QM_ELIG = “T21”
If Eligibility Contract_Type = “Anything Else” then QM_ELIG = “T19”
If there is no matching eligibility segment, then QM_ELIG = “NON”
If AGE < 18 and (Demographic Behavioral_Health_Category_Code = *Any value or there is no matching Demographic segment*), then QM_BHC = “Child”
If AGE => 18 and Demographic Behavioral_Health_Category_Code = “C” or “M” then
QM_BHC = “GMH”
If AGE => 18 and Demographic Behavioral_Health_Category_Code = “G” then
QM_BHC = “SA”
If AGE => 18 and Demographic Behavioral_Health_Category_Code = “S” then
QM_BHC = “SMI”
If AGE => 18 and (Demographic Behavioral_Health_Category_Code = *Any other value or there is no matching Demographic segment*), then QM_BHC = “GMH”
End If

12. Counting enrollments is a process by which each behavioral health recipient is placed in one distinct category and counted only once. Place each enrollment segment in the appropriate category based on QM_BHC (defined in D11) as follows:

Child includes New_BHC = “Child”
CMDP-Total includes New_BHC = “CMDP”
Non-SMI includes New_BHC = “GMH”, “SA”
SMI includes New_BHC = “SMI”

13. T/RBHA eligible counts are based on the At Risk snapshot table provided by AHCCCS. RBHA’s are determined using counties and T/RBHA’s are determined using zip code definitions provided by AHCCCS. Contract type and behavioral health categories are determined using a combination of codes as follows:

Title XIX child includes CTRT_TYP = K and MH_CATEGORY = C
Title XIX CMDP child includes CTRT_TYP = 7 and MH_CATEGORY = C
Title XIX adult includes CTRT_TYP = K, 6, 7 and MH_CATEGORY = S
Title XXI child includes CTRT_TYP = V and MH_CATEGORY = C
Title XXI adult includes CTRT_TYP = V, Z and MH_CATEGORY = S

14. Penetration is determined by dividing the Enrollment counts (D10) by the Eligible counts (D13) within designated categories (defined in D11) as follows:

Child Enrollment ÷ Child Eligibility
CMDP Enrollment ÷ CMDP Eligibility

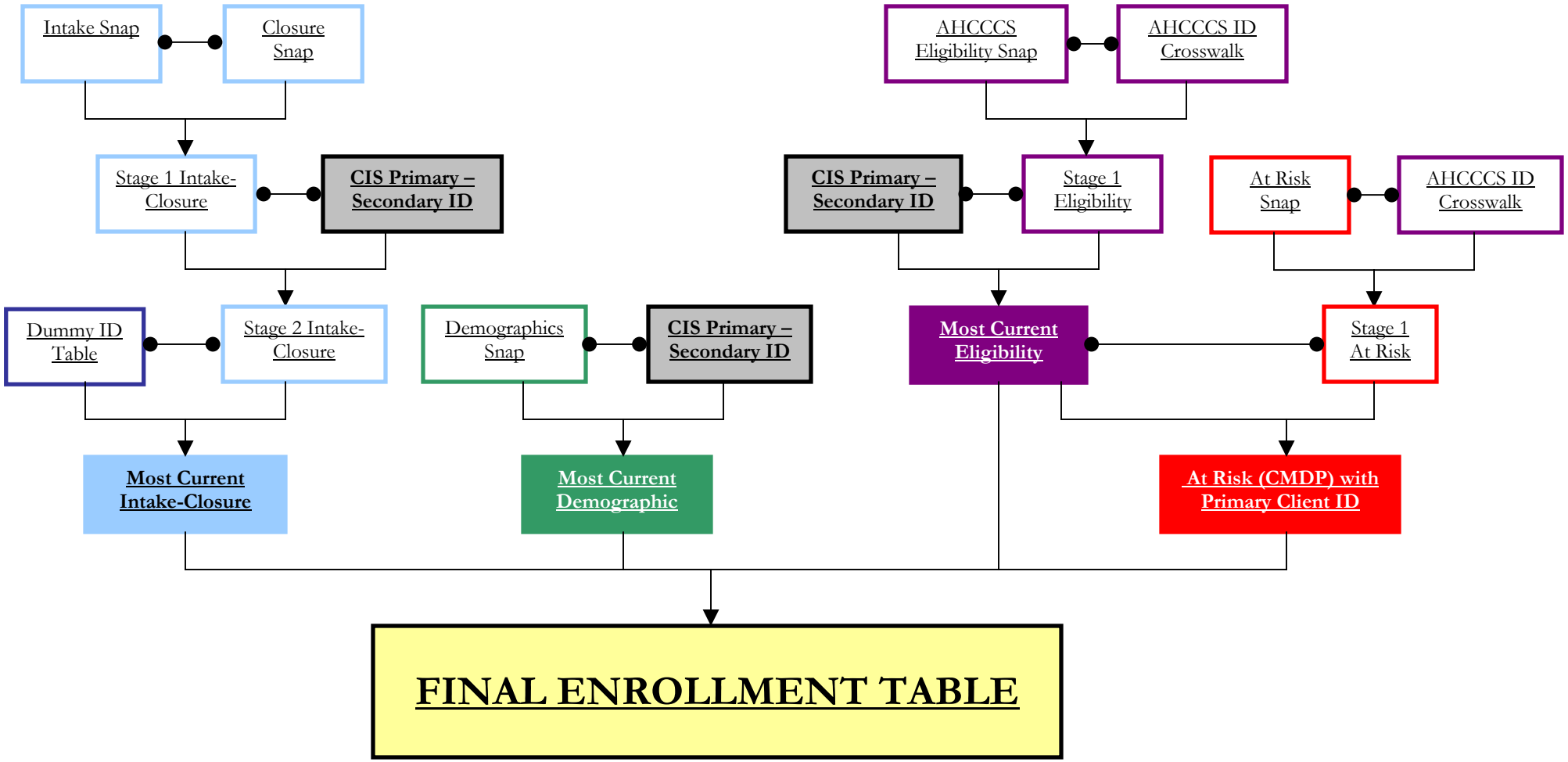
Non-SMI Enrollment ÷ Adult Eligibility
SMI Enrollment ÷ Adult Eligibility

Please refer to Flow Chart (Attachment A).

E. SPECIAL CASES:

1. Primary/Secondary CIS Client IDs for the same behavioral health recipient (combined under Primary CIS Client ID)
2. Dummy CIS Client IDs (removed from enrollment extract)
3. Overlapping intakes at the same or multiple T/RBHAs with or without a closure date. The most current enrollment is selected.
4. Overlapping AHCCCS eligibility segments at the same or multiple T/RBHAs with or without an end date. The most current eligibility segment is selected.
5. Beginning in December 2004, AHCCCS began converting social security number IDs to an Alpha-Numeric ID. Therefore, the AHCCCS SSN Crosswalk Snapshot must be used to identify the Primary AHCCCS ID.
6. There are multiple Client IDs associated to the same AHCCCS ID in the AHCCCS Eligibility Snapshot table. Since the AHCCCS At Risk Snapshot table does not include a CIS Client ID, the Eligibility table is used to obtain the CIS Client ID and any multiple records based on Primary AHCCCS ID must be eliminated. The ClS Client ID is chosen from the most current Eligibility segment.

ADHS/DBHS Enrollment Protocol Flow Chart
Used to determine BHC, Eligibility, Age, & Demographics



ENROLLMENT – PENETRATION PROTOCOL FOR SPECIAL POPULATIONS

PERFORMANCE MEASURE INCENTIVES

DESCRIPTION

For the Greater Arizona contracts, ADHS has identified 6 Performance Measures to be calculated annually, with incentives paid out for achievement at or above the minimum performance standard. Those measures are:

1. Symptomatic Improvement
2. Overall WFI score
3. Coordination of Care with the PCP
4. Cultural Competency
5. Member/Family Involvement
6. Overall Satisfaction

MINIMUM PERFORMANCE STANDARDS

Symptomatic Improvement: 85%
Overall WFI score: 65%
Coordination of Care with PCP: 80%
Cultural Competency: 75%
Member/Family Involvement: 85%
Overall Satisfaction: 85%

ELIGIBILITY

In order for the RBHA to be eligible for consideration of financial incentives, ADHS must first determine if it meets the standard for submission of timely, complete, and accurate data reporting. Encounter data must be submitted in compliance with the Program Support Procedures Manual

METHODOLOGY

Population
All Title XIX/XXI eligible children and adults for whom performance measures are calculated or WFI interviews are conducted.

Reporting Frequency
Quarterly for Coordination of Care and overall WFI score with an annual roll-up.

Annually for Symptomatic Improvement, Cultural Competency, Member/Family Involvement, and Overall Satisfaction.

Data Source
Symptomatic Improvement: Behavioral Health Recipient Satisfaction Survey
Overall WFI score: WFI interviews
Coordination of Care with PCP (measure #1): CIS, Record Review
Cultural Competency: Behavioral Health Recipient Satisfaction Survey
Member/Family Involvement: Behavioral Health Recipient Satisfaction Survey
Overall Satisfaction: Behavioral Health Recipient Satisfaction Survey

Please see the corresponding Performance Measure specifications for the actual questions on the Behavioral Health Recipient Satisfaction survey that correspond with the Measure.

Calculation
Once the RBHA is determined eligible to receive the incentive based on encounter submission, the annual scores for each performance measure are reviewed to determine if they met the minimum performance threshold established in Section F, Financial Provisions, paragraph 1.c of the Greater Arizona contract. For measures that are calculated for both children and adults, the minimum performance threshold must be met for both populations. Incentives are calculated the following March for the previous fiscal year.

Data Reporting
Data is reported separately for each GSA and population (Child, Adult), as applicable.

QUALITY CONTROL

Data for the Behavioral Health Satisfaction Survey is double entered into an Access database, with noted discrepancies highlighted and referred back to the original document for correction. Refer to the applicable Performance Measure specification for additional information on quality control.

CONFIDENTIALITY PLAN

Data is presented in aggregate form and does not contain individual identifying information. Refer to the applicable Performance Measure specification for additional information on confidentiality.

ANNUAL MHSIP CONSUMER SATISFACTION SURVEY PERFORMANCE MEASURES

CULTURAL COMPETENCY
INFORMED CONSENT
SYMPTOMATIC IMPROVEMENT
MEMBER/FAMILY INVOLVEMENT

MINIMUM PERFORMANCE STANDARDS

1. Cultural Competency:
   Minimum: 75%
   Goal: 85%
   Benchmark: 95%
2. Informed Consent:
   Minimum: 85%
   Goal: 90%
   Benchmark: 95%
3. Symptomatic Improvement:
   Minimum: 85%
   Goal: 90%
   Benchmark: 95%
4. Member/Family Involvement:
   Minimum: 85%
   Goal: 90%
   Benchmark: 95%

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
Title XIX / XXI eligible adults and children.

Reporting Frequency
Annually.

Data Source
1. MHSIP Adult Consumer Survey
2. MHSIP Youth Consumer survey

Calculation

1. **Cultural Competency** –
   Question scored, Adult:
   #44 – My cultural preferences and race/ethnicity were included in planning the services I received.
   Question scored, Youth:
   #15 – Staff were sensitive to my cultural/ethnic background.

2. **Informed Consent** –
   Question scored, Adult:
   #37 – My doctor explained the benefits, risks, and alternatives of medications prescribed for me and I understood.
   Question scored, Youth:
   #38 – My child's doctor explained the benefits, risks, and alternatives of medications prescribed for him/her and I understood.

3. **Symptomatic Improvement** –
   Question scored, Adult:
   #28 – My symptoms are not bothering me as much.
   Question scored, Youth:
   #36 – My child's symptoms are not bothering him/her as much.

4. **Member/Family Involvement** –
   Question scored, Adult:
   #42 – My family is as involved as I want them to be in my treatment.

Sampling Method – Design

RBHA

A sample frame of the population eligible to take the survey is developed. This provides the pool from which the sample size is determined and the sample population is randomly selected. Two sample frames are developed for each RBHA: one for adults and one for children.

The adult population is defined as behavioral health recipients aged 18 and older. These behavioral health recipients are enrolled in any of the adult programs: General Mental Health, Substance Abuse, or Serious Mental Illness. The children's population is composed of behavioral health recipients aged 17 and under. Age is calculated at the time of creation of the sample frame. In cases where there is a discrepancy between the age of the behavioral health recipient and the behavioral health category, the behavioral health recipient is grouped according to the identified behavioral health category.

The sample frame is composed of all Title XIX/XXI behavioral health recipients enrolled as of the date when the sample frame is developed and meet the eligibility criteria:

(a) behavioral health recipient must have a community-based mental health service other than transportation, laboratory and/or radiology services, and crisis;
(b) service must have been received within 6 months prior to the sample pull; and
(c) behavioral health recipient must not be receiving services in an inpatient treatment setting at the time the sample frame is developed.

In addition to the above, the following behavioral health recipients are excluded from the sample frame:

Behavioral health recipients receiving services from fee-for-service providers
Due to administrative burden, fee for service providers are excluded.

Sampling Method – Drawing of Sample

A statistically valid sample size for adults and children is drawn for each RBHA, and distributed according to enrollment size across the providers. The sample size is determined using a 90% confidence level, with a margin of error of +/- 5%. The determined sample size is adjusted by 50% to allow for over-sampling of cases. Theoretically, the 50% over-sample should address the expected rate of non-participation as a result of behavioral health recipient no-show for scheduled appointment or non-response (either as a choice made by the behavioral health recipient or the sample behavioral health recipient has no scheduled appointment).

A stratified random sampling method through utilizing the SPSS random sampling program is used to identify the sample population. ADHS provides the RBHAs with the calculated sample size as well as the number of sample cases to be selected from each of its provider agencies based on their respective enrollment size. The RBHA then conducts a stratified random selection of behavioral health recipients. Once the sample population has been randomly selected, each provider agency is
advised of its sample population. Each provider then conducts a review of the list to determine that at least 85% of the sample has scheduled appointments. The random selection process is repeated until this criterion is satisfied. To ensure that each behavioral health recipient has equal probability of being selected, behavioral health recipients are linked to one provider – the provider where their clinical liaison is affiliated. Once the sample population has been finalized, a control file is created and sent to each of the participating provider agencies. Each provider agency is responsible for identifying the specific provider location or site to which the behavioral health recipient is receiving services at the time of the survey.

TRBHA

The survey is administered utilizing a convenient sample methodology, with all behavioral health recipients who come to the TRBHA/provider site during the survey administration period offered an opportunity to participate.

Distribution Method

The primary distribution method is handing the survey questionnaire to the behavioral health recipient at the provider office (i.e., clinic) by a non-clinical staff. As the behavioral health recipient checks in for their appointment, s/he is provided with a copy of the survey questionnaire to complete. If the behavioral health recipient agrees to participate, s/he is requested to complete the survey prior to his/her appointment. If the behavioral health recipient is unable to complete the questionnaire, s/he is allowed to finish it on site after the appointment or is provided with an addressed, stamped envelope to mail the survey in if they do not have time to complete it in the office. A drop box is provided on site for completed surveys. Additionally, a specific area at the provider office is designated for completing the survey. If the behavioral health recipient randomly selected (RBHA only) has a scheduled appointment at home during the survey window, the provider staff will bring the survey questionnaire at the appointment date. If the behavioral health recipient agrees to participate, s/he will be advised to complete the survey after the staff leaves and to mail the completed questionnaire using the pre-addressed, stamped envelope provided with the survey. A check box in the questionnaire is used to track the distribution method. If there are a sufficient number of cases using each method, the results will be reported separately. Otherwise, all responses irrespective of the distribution method used are combined and analyzed.

Calculations:

Scoring Protocol

The scoring protocol recommended by MHSIP is utilized for evaluating the domain areas within the survey, as follows:

1. Recode ratings of 'not applicable' as missing values.
2. Exclude respondents with more than one-third of the domain items missing.
3. Calculate the mean of the items for each respondent.
4. Calculate the percent of scores that are greater than 3.5

Numerator: Number of survey respondents reporting positively (greater than 3.5) to question associated with specific measure.

Denominator: Number of surveys with response to question associated with specific measure.

Response Rate Calculation

The rate is calculated using the formula: Response rate = A / B. Where:

A= Total number of surveys returned

B= Total number of behavioral health recipients approached or administered the survey

Weighting Methodology

To account for any potential bias created by non-response or over-representation of a particular area, a weighting methodology is used to adjust the data. Weights are applied to the survey data prior to any data analysis.

Data Reporting:

Data is reported by GSA and population (adult, child).

QUALITY CONTROL

The survey is administered to a statistically valid sample of currently enrolled adults and children receiving behavioral health services using a 90% confidence level and a +/- 5% margin of error, with each RBHA's sample number distributed according to enrollment size across the RBHA's providers. Statistical adjustments are applied to data obtained through survey results to correct biases that could be created by non-response or unequal response rates across RBHAs. Weights are applied to the data based on the RBHA population eligible to participate in the survey as a selected respondent. Consumer survey data is double-entered into an Access database. Discrepant entries are flagged and reviewed against the survey form for correction.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

APPROPRIATENESS OF SERVICES

DESCRIPTION

The types and intensity of services, including case management, are provided based on the client's assessment and treatment recommendations.

MINIMUM PERFORMANCE STANDARD

Minimum: 85 %
Goal: 90 %
Benchmark: 95 %

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
Sample of Title XIX/XXI children and adults receiving behavioral health services.

Review Frequency
Quarterly, on the 30th day following the end of the quarter. A 3-month lag time is applied to accommodate record review.
*Note: TRBHAs reviews occur twice annually (January and July).

1. ADHS/DBHS Office of Monitoring & Oversight informs the T/RBHA via letter and/or Email of client charts selected for review one (1) month prior to on-site review.
2. ADHS/DBHS Office of Monitoring & Oversight conducts chart reviews for all T/RBHAs to determine if services provided are based on the clients' assessment and treatment recommendations.

Data Source
1. Client Information System (CIS)
2. Record Review by ADHS

Methodology
1. For each GSA, ADHS/DBHS randomly selects 40 TXIX/XXI clients (*10 per population, i.e. Child, SMI, GMH and SA)* utilizing the following inclusion criteria:
   a. Clients enrolled as of the first day of the reporting quarter and have been continuously enrolled for at least 90 days in the prior 6 months;

b. Clients have received services other than **ONLY** a transportation, lab, radiology, pharmacy, case management, inpatient service, methadone treatment or crisis service.

2. Numerator = Number of TXIX/XXI records reviewed that document the types and intensity of services, including case management, are provided based on the client's assessment and treatment recommendations.
   Denominator = Number of TXIX/XXI records reviewed.

QUALITY CONTROL

Inter-rater reliability studies are conducted after each review by the manager of the Office of Monitoring and Oversight for all staff involved in data collection to ensure consistency in scoring. Retraining is conducted for any staff identified as an outlier.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

SUFFICIENCY OF ASSESSMENTS

DESCRIPTION

Assessments are sufficiently comprehensive for the development of functional treatment recommendations.

MINIMUM PERFORMANCE STANDARD

Minimum: 85 %
Goal: 90 %
Benchmark: 95 %

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
Title XIX/XXI children and adults.

Review Frequency
Quarterly, on the 30th day following the end of the quarter.

Data Source
Client Information System (CIS)

Methodology
1. 100% of demographic intakes submitted during the reporting quarter.
2. Numerator = Number of demographic records for TXIX/XXI behavioral health recipients submitted to the ADHS/DBHS Client Information System (CIS) and accepted as complete.
   Denominator = Number of demographic records for TXIX/XXI behavioral health recipients submitted to the ADHS/DBHS Client Information System (CIS).

QUALITY CONTROL

The accuracy and completeness of data submitted by the RBHAs to ADHS/DBHS' Client Information System (CIS) is ensured through pre-processor edits and data validation review of behavioral health recipient medical records by the Office of Program Support.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the RBHA level, and is not presented at an individual client level.

QUALITY OF ASSESSMENTS

DESCRIPTION

The initial and annual assessments are complete and sufficient to develop functional treatment recommendations.

MINIMUM PERFORMANCE STANDARD

Minimum: 85 %
Goal: 90 %
Benchmark: 95 %

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
Sample of Title XIX/XXI children and adults receiving behavioral health services.

Review Frequency
Quarterly, on the 30th day following the end of the quarter.
*Note: TRBHA reviews occur twice annually (January and July).

1. ADHS/DBHS Office of Monitoring & Oversight informs the T/RBHA via letter and/or Email of client charts selected for review one (1) month prior to on-site review.
2. ADHS/DBHS Office of Monitoring & Oversight conducts a quarterly chart review for all T/RBHAs to determine if services provided are based on the client's assessment and treatment recommendations.

Data Source
1. Client Information System (CIS)
2. Record Review by ADHS

Methodology
1. For each GSA, ADHS/DBHS randomly selects 40 TXIX/XXI clients (*10 per population, i.e. Child, SMI, GMH and SA)* utilizing the following inclusion criteria:
   a. Clients enrolled as of the first day of the reporting quarter and have been continuously enrolled for at least 90 days in the prior 6 months;
   b. Clients have received services other than **ONLY** a transportation, lab, radiology, pharmacy, case management, inpatient service, methadone treatment or crisis service.

2. Numerator = Number of initial and annual assessments that include all the required elements of the assessment and are clinically sound and complete.
   Denominator = Number of TXIX/XXI records reviewed.

QUALITY CONTROL

Inter-rater reliability studies are conducted after each review by the manager of the Office of Monitoring and Oversight for all staff involved in data collection to ensure consistency in scoring. Retraining is conducted for any staff identified as an outlier.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

COORDINATION OF CARE

DESCRIPTION

1. The disposition of the referral is communicated to the PCP/Health Plan within 45 days of initial assessment or, behavioral health services are declined, within 45 days of the referral.
2. Behavioral health service providers communicate with and attempt to coordinate care with the member's Primary Care Physician (PCP)/Health Plan.

MINIMUM PERFORMANCE STANDARD

1. Minimum: 80 %
   Goal: 90 %
   Benchmark: 95 %

2. Minimum: 70 %
   Goal: 80 %
   Benchmark: 90 %

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population

1. COC 1 (Referral) – Title XIX/XXI Children and Adults referred by the AHCCCS PCP/Health Plan for behavioral health services
2. COC 2 (Communication) – Title XIX/XXI Children with an Axis III diagnosis; Title XIX/XXI Adults with an SMI and/or Axis III diagnosis; Non-Title XIX SMI adults with an Axis III diagnosis.

Reporting Frequency

Quarterly. 30th day following the end of the quarter. ADHS/DBHS provides the sample to the RBHAs Month 2 of Reporting Quarter, Day 15.

Reporting Format

See attached "Electronic Quality Management Report Template".

Data Source

1. COC 1 (Referral) – RBHA submitted referral logs (Referral Source Code 35).
2. COC 2 (Communication) - Client Information System (CIS), RBHA submitted documentation by population.
3. RBHA Record Review (COC 1 and COC 2)

Record Selection

1. COC 1 (Referral)

a. Title XIX/XXI behavioral health recipients referred by the PCP / Health Plan during the last month of the previous reporting quarter.
b. Adult - If greater than 100 individuals, a random sample that utilizes a 90% confidence level with a 5% error rate is pulled.
c. Children - If greater than 100 individuals, a random sample that utilizes a 90% confidence level with a 5% error rate is extracted.

2. COC 2 (Communication)
    a. Title XIX/XXI behavioral health recipients with SMI and/or a chronic medical condition [Axis III].
    b. Adult – A random sample that utilizes a 90% confidence level with a 5% error rate, divided by four (4) for quarterly sample.
    c. Children – A random sample that utilizes a 90% confidence level with a 5% error rate, divided by four (4) for quarterly sample.

Calculation

1. COC 1 (Referral)
    a. Numerator = Number of records that contain documentation of communication of the disposition of the referral back to the PCP / Health Plan within the required timeframes.
    b. Denominator = Number of behavioral health recipients referred by the PCP /health plan.
2. COC 2 (Communication)
    a. Numerator = Number of sample records that contain documentation of coordination of care within the required timeframes.
    b. Denominator = Number of sample records obtained from CIS demographic data identified as Title XIX/XXI behavioral health recipients with SMI and/or chronic medical condition [Axis III].

Documentation Requirements:
For the purpose of determining the presence of adequate documentation, a minimum of one of the following must be evidenced in the record:

COC 1 (Referral**)**
1.) ADHS/DBHS Referral for Behavioral Health Services PM Form 3.3.1 or similar document completed in its entirety. PM Form 3.3.1 can be accessed in Section 3.3, Referral Process, of the ADHS/DBHS Provider Manual.

2.) ADHS/DBHS PM Form 4.3.1, Communication Document, or similar document completed in its entirety. PM Form 4.3.1 can be accessed in Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, of the ADHS/DBHS Provider Manual.

3.) Progress Note, dated and typed or legibly written, that clearly identifies the occurrence of required communication.

COC 2 (Communication)
1.) ADHS/DBHS PM Form 4.3.1, Communication Document, or similar document completed in its entirety. PM Form 4.3.1 can be accessed in Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, of the ADHS/DBHS Provider Manual.
2.) Progress Note, dated and typed or legible written, that clearly identifies the occurrence of required communication.

QUALITY CONTROL

The accuracy and completeness of all required fields on the referral logs submitted by the RBHAs to ADHS/DBHS are checked programmatically and used to calculate error rates. Errors are identified as erroneous or missing data in any of the referral log fields except BHS Client ID. Error rates cannot exceed 5% per GSA per reporting quarter. RBHAs are subject to corrective action, up to and including sanctions, if the error rate exceeds 5% for two consecutive quarters.

ADHS/DBHS periodically requests RBHAs to submit supporting documentation to verify the accuracy of reported data and validate findings. Discrepant findings result in corrective actions and may result in modifications to performance findings for the applicable reporting period.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the RBHA level, and is not presented at an individual member level.

APPOINTMENT AVAILABILITY FOR INITIAL ASSESSMENT

DESCRIPTION

Appointments are available to individuals referred for/requesting services within the contractually required timelines (routine assessments within 7 days of referral).

MINIMUM PERFORMANCE STANDARD

Minimum:	85%
Goal:	90%
Benchmark:	95%

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
Title XIX/XXI children and adults.

Review Frequency
1. Referral logs are due to ADHS/DBHS by the 15th of each month for referrals received during the previous month. Referral logs, in comma delimited text format, are placed by each T/RBHA in its T/RBHA-specific named folder, on the ADHS/DBHS network server. ADHS/DBHS has developed strict guidelines regarding data that is required to be included on the monthly referral logs. (See Attachment A for file layout)
2. Access to Care/Routine Appointment Availability is aggregated for quarterly reporting.

Data Source
T/RBHA Referral Logs

Methodology
1. Referrals that contain a "Yes" in the "Title XIX/XXI" field and contain no errors in certain fields are used to calculate compliance with this measure. The following four fields must be error-free:
   a. Referral Date
   b. First Appointment Offered Date
   c. Program Type
   d. TXIX/XXI Field

2. Calculate number of days between Referral Date and First Appointment Offered Date.
   a. Number of days = Offered Date – Referral Date.
3. Calculate referrals that are in compliance and out of compliance.
   a. Referrals with < = 7 days from Referral Date to First Appointment Offered Date are in compliance;
   b. Referrals with > = 8 days from Referral Date to First Appointment Offered Date are non-compliant.
4. Referrals are further stratified by Title XIX/XXI children and adults.
   a. Adults are calculated using referrals with S, M, or G indicated as Program Type.
   b. Children are calculated using referrals with C or Z indicated as Program Type.

QUALITY CONTROL

ADHS/DBHS programmatically reviews T/RBHA-submitted referral logs for completeness and accuracy of Access to Care data submitted. ADHS provides technical assistance to the T/RBHAs when necessary to improve data collection methods and ensure data submitted to ADHS/DBHS is valid.

ERROR RATE 5%

All fields on the attached Referral Log Column Layout with the exception of BHS Client ID are considered in the calculation of error rates. Errors are identified as erroneous or missing data in any of the referral log fields, except BHS Client ID. Error rates cannot exceed 5% per GSA, per reporting quarter. T/RBHAs are subject to corrective action, up to and including sanctions, if the error rate exceeds 5% for two consecutive quarters.

Two calculations are used to report referral log errors:
1. Field percentage of error = Number of field errors / Number of referrals * 100.
   a. Example: 120 Referrals, 3 Errors in "Referral Date" field = 3 / 120 * 100 = 2.5% error rate for "Referral Date" field.
2. Total percentage of error = Total number of errors / (Number of fields * Number of Referrals) * 100.
   a. Example: 120 Referrals, 3 Errors in "Referral Date" field, 4 Errors in "Program Type" field = 7 / (10 * 120) * 100 = .58% total error rate.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the T/RBHA level, and is not presented at an individual client level.

ROUTINE ASSESSMENTS OFFERED WITHIN 7 DAYS OF REFERRAL

REFERRAL LOG COLUMN LAYOUT

Update Date: 10/12/05

Field Name	Definition	Format	Remarks
Title XIX/XXI	Eligibility at Referral.	Text: (1 character) Y, N, U Default: UNKNOWN	Y = Yes, N = No, U = UNKNOWN
Program Type	CHILD, SMI, GMH, SA, SED	Text: C, S, M, G, Z (1 character)	C = Child, S = SMI, M = GMH, G = SA, Z = SED If not enrolled, enter Child or GMH based on age.
Referral Source	Entity or person making referral.	Text: 2 characters Codes match the CIS demographic data definitions for "Referral Source"	01= Self/family/friend 03= Other behavioral health provider 19= Federal agencies (VA, HIS, federal prison, etc.) 35= AHCCCS health plan **and/or PCP** 36= CPS 24-hour urgent response (child) 37= Community agency other than behavioral health provider (homeless shelter, church, employer) 38= ADES (Other CPS, DDD, RSA) 39= ADE – Department of Education 40= Criminal justice/correctional (includes AAOC probation, ADOC, ADJC, Jail) 41= Other (anything not captured above)
Client Last Name		Text: 15 characters	
Client First Name		Text: 10 characters	
Date of Birth		Text: yyyymmdd (8 characters)	
BHS Client ID*	ADHS/BHS client ID number.	Text: 10 character	
Referral Date	Date of referral/contact.	Text: yyyymmdd (8 characters)	
Date First Appointment Offered	Date of first offered appointment.	Text: yyyymmdd (8 characters)	
Date Appointment Scheduled	Date of actual appointment.	Text: yyyymmdd (8 characters)	
AHCCCS Provider ID	Agency providing service.	Text: 10 characters	Valid AHCCCS Provider ID

*This field is not mandatory and will not be considered when calculating error rates.

ROUTINE APPOINTMENT FOR ONGOING SERVICES WITHIN 23 DAYS OF INITIAL ASSESSMENT (ASSESSMENT TO FIRST SERVICE)

DESCRIPTION

Routine appointments for ongoing services are received within 23 days after initial assessment.

MINIMUM PERFORMANCE STANDARD

Minimum:	90%
Goal:	95%
Benchmark:	100%

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
Title XIX/XXI children and adults

Review Frequency
ADHS/DBHS calculates this performance measure for the reporting quarter, 15 days after the end of the subsequent quarter, allowing a 3 month lag time for encounter submission.

Data Source
Client Information System (CIS)

Methodology

1. ADHS receives the behavioral health recipient enrollment data from the T/RBHAs via Client Information System (CIS).

2. The performance measure has a minimum encounter data submission requirement consistent with Financial Operations. Attachment B outlines minimum performance standards for usable data.

Calculation

1. The percentage of Usable Enrollments is calculated:
   Numerator = Number of Usable Enrollments
   Denominator = Total Number of Enrollments

2. The percentage of compliance in providing a service within 23 days after assessment is calculated:
   Numerator = Number of behavioral health recipients with an intake date during the reporting period with a corresponding assessment encounter within 45 days of the intake date and with an ongoing service encounter within 23 days after the assessment.
   Denominator = Total number of behavioral health recipients with an intake date during the reporting period with a corresponding assessment encounter within 45 days of the intake date (usable enrollments).

QUALITY CONTROL

The accuracy and completeness of data submitted by the RBHAs to ADHS' Client Information System (CIS) is ensured through pre-processor edits and random data validation review of behavioral health recipient medical charts.

UNUSABLE DATA

In the event that the prevalence of unusable data (intakes without an assessment encounter within 45 days of intake date) prevents assessment of compliance with this performance measure, ADHS may require documentation from medical chart audits to substantiate the provision of service.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the RBHA level, and is not presented at an individual client level.

DEFINITIONS

1. Assessment
   - The ongoing collection and analysis of a person's medical, psychological, psychiatric, and social condition in order to initially determine if a behavioral health disorder exists and if there is a need for behavioral health services and on an ongoing basis ensure that the person's service plan is designed to meet the person's (and family's) current needs and long-term goals. For the purpose of this performance measure, the assessment must occur within 45 days from the date of Intake. The assessment date is obtained from encounter data. The following codes are used to identify an assessment:

a. CPT Codes: 90801, 90802, 90885, 96100, 96101, 96102, 96103, 96110, 96111, 96115, 96116, 96117, 96118, 96119, 96120, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275
b. HCPCS Codes: H0002, H0031

2. Encounter
   - A record of a service rendered by a registered AHCCCS provider to an AHCCCS enrolled behavioral health recipient. RBHAs have 210 days to submit encounter data to ADHS and 120 days to process pended encounter data. Lag time allows for the provider to submit encounter data to the RBHA and, in turn, the RBHA submission to ADHS.

3. Intake
   - The collection by appropriately trained T/RBHA/Provider staff of basic demographic information about a person in order to enroll him/her in the ADHS/DBHS system, to screen for Title XIX/XXI AHCCCS eligibility and to determine the need for any co-payments.

4. Usable Data
   - Behavioral health recipients with an intake date during the reporting period with a corresponding assessment encounter. The assessment must have occurred within 45 days of the intake date. See Attachment B for minimum standards for usable data.

5. Unusable Data
   - Behavioral health recipients with an intake date during the reporting period but no corresponding assessment encounter data or the assessment occurred more than 45 days after the intake date.

6. First Service
   - The first service is obtained from the encounter data. There are limitations on the type of billable service rendered within 23 days after assessment that qualify as a first service **if it occurs on the same day as the assessment**. The following comprehensive behavioral health service categories are **excluded** as a first service if it occurs on the same day as the assessment.
     - A. 2. Assessment, Evaluation and Screening Services
     - B. 3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
     - B. 4. Psychoeducational Services and Ongoing Support to Maintain Employment
     - C. 2. Laboratory, Radiology and Medical Imaging
     - C. 4. Electro-Convulsive Therapy
     - D. 1. Case Management
     - D. 8. Sign Language or Oral Interpretive Services
     - D. 9. Non-Medically Necessary Covered Services (Flex Fund Services)

- D. 10. Transportation
- G. 3. Mental Health Services NOS (Room and Board)
- I. Prevention Services

Behavioral health recipients may receive any covered service on the same day as the initial assessment, but only included services will be considered in calculation of the performance measure.

See Attachment A for procedure codes that are included/excluded from qualifying as a first service if it occurs on the same day as the assessment. An assessment provided a minimum of one (1) day after the initial assessment would qualify as a first service.

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
W4084	Include	Behavioral health day program-medical (6 hours or more) (per day	Programs	Medical
W4083	Include	Behavioral health day program-medical (min of 3 hours and less th	Programs	Medical
W4082	Include	Behavioral health day program-medical (60 min.)	Programs	Medical
W4081	Include	Behavioral health day program-medical (6 hours or more) (per day)	Programs	Medical
W4080	Include	Behavioral health day program-medical (min of 3 hours and less th	Programs	Medical
W4079	Include	Behavioral health day program-medical (60 min.)	Programs	Medical
W4078	Include	Behavioral health day program-therapeutic (6 hours or more) (per	Programs	Therapeutic
W4077	Include	Behavioral health day program-therapeutic (min. of 3 hours and le	Programs	Therapeutic
W4076	Include	Behavioral health day program-therapeutic (60 min.)	Programs	Therapeutic
W4075	Include	Behavioral health day program-therapeutic (6 hours or more) (per	Programs	Therapeutic
W4074	Include	Behavioral health day program-therapeutic (min. of 3 hours and le	Programs	Therapeutic
W4073	Include	Behavioral health day program-therapeutic (60 min.)	Programs	Therapeutic
W4072	Include	Behavioral health day program-supervised (6 hours or more) (per d	Programs	Supervised
W4071	Include	Behavioral health day program-supervised (min. of 3 hours and les	Programs	Supervised
W4070	Include	Behavioral health day program-supervised (60 min.)	Programs	Supervised
H2020	Include	Therapeutic behavioral services, per diem	Programs	Therapeutic
H2019	Include	Therapeutic behavioral services day program, per 15 minutes up to	Programs	Therapeutic
H2015	Include	Comprehensive community support services, supervised day program	Programs	Supervised
H2012	Include	Supervised behavioral health day treatment, per hour up to 5 hour	Programs	Supervised
H0037	Include	Community psychiatric supportive treatment medical day program, p	Programs	Medical
H0036	Include	Community psychiatric supportive treatment day program, face-to-f	Programs	Medical
W4063	Include	Crisis intervention mobile team (2 person) (30 min.)	Crisis Intervention Services	Mobile
W4062	Include	Crisis intervention mobile (1 person/out of office) (30 min.)	Crisis Intervention Services	Mobile
W4061	Include	Crisis intervention-urgent (5 to 23 hours) (per visit)	Crisis Intervention Services	Crisis Services
W4060	Include	Crisis intervention-urgent (up to 5 hours) (30 min.)	Crisis Intervention Services	Crisis Services
S9485	Include	Crisis intervention mental health services, per diem	Crisis Intervention Services	Crisis Services
S9484	Include	Crisis intervention mental health service, per hour	Crisis Intervention Services	Crisis Services
H2011	Include	Crisis intervention service, per 15 minutes	Crisis Intervention Services	Crisis Services
99285	Include	Emergency department visit for the evaluation and management of a	Crisis Intervention Services	Crisis Services
99284	Include	Emergency department visit for the evaluation and management of a	Crisis Intervention Services	Crisis Services
99283	Include	Emergency department visit for the evaluation and management of a	Crisis Intervention Services	Crisis Services
99282	Include	Emergency department visit for the evaluation and management of a	Crisis Intervention Services	Crisis Services
99281	Include	Emergency Dept Visit for the evaluation and management of a patie	Crisis Intervention Services	Crisis Services
99357	Include	Prolonged physician services in the inpatient setting, requiring	Inpatient Services	Professional
99356	Include	Prolonged physician services in the inpatient setting, requiring	Inpatient Services	Professional
99263	Include	Follow-up inpatient consultation for an established patient, whic	Inpatient Services	Professional

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
99262	Include	Follow-up inpatient consultation for an established patient, whic	Inpatient Services	Professional
99261	Include	Follow-up inpatient consultation for an established patient, whic	Inpatient Services	Professional
99255	Include	Initial inpatient consultation for a new or established patient,	Inpatient Services	Professional
99254	Include	Initial inpatient consultation for a new or established patient,	Inpatient Services	Professional
99253	Include	Initial inpatient consultation for a new or established patient,	Inpatient Services	Professional
99252	Include	Initial inpatient consultation for a new or established patient,	Inpatient Services	Professional
99251	Include	Initial inpatient consultation for a new or established patient,	Inpatient Services	Professional
99239	Include	Hospital discharge day management; more than 30 minutes	Inpatient Services	Professional
99238	Include	Hospital discharge day management	Inpatient Services	Professional
99236	Include	Observation or inpatient hospital care, for the evaluation and ma	Inpatient Services	Professional
99235	Include	Observation or inpatient hospital care, for the evaluation and ma	Inpatient Services	Professional
99234	Include	Observation or inpatient hospital care, for the evaluation and ma	Inpatient Services	Professional
99233	Include	Subsequent hospital care, per day, for the evaluation and managem	Inpatient Services	Professional
99232	Include	Subsequent hospital care, per day, for the evaluation and managem	Inpatient Services	Professional
99231	Include	Subsequent hospital care, per day, for the evaluation and managem	Inpatient Services	Professional
99223	Include	Initial hospital care, per day, for the evaluation and management	Inpatient Services	Professional
99222	Include	Initial hospital care, per day, for the evaluation and management	Inpatient Services	Professional
99221	Include	Initial hospital care, per day, for the evaluation and management	Inpatient Services	Professional
99220	Include	Initial observation care, per day for the evaluation and manageme	Inpatient Services	Professional
99219	Include	Initial observation care, per day for the evaluation and manageme	Inpatient Services	Professional
99218	Include	Initial observation care, per day, for the evaluation and managem	Inpatient Services	Professional
90829	Include	Individual psychotherapy, interactive, using play equipment, phys	Inpatient Services	Professional
90828	Include	Individual psychotherapy, interactive, using play equipment, phys	Inpatient Services	Professional
90827	Include	Individual psychotherapy, interactive, using play equipment, phys	Inpatient Services	Professional
90826	Include	Individual psychotherapy, interactive, using play equipment, phys	Inpatient Services	Professional
90824	Include	Individual psychotherapy, interactive, using play equipment, phys	Inpatient Services	Professional
90823	Include	Individual psychotherapy, interactive, using play equipment, phys	Inpatient Services	Professional
90822	Include	Individual psychotherapy, insight oriented, behavior modifying an	Inpatient Services	Professional
90821	Include	Individual psychotherapy, insight oriented, behavior modifying an	Inpatient Services	Professional
90819	Include	Individual psychotherapy, insight oriented, behavior modifying an	Inpatient Services	Professional
90818	Include	Individual psychotherapy, insight oriented, behavior modifying an	Inpatient Services	Professional
90817	Include	Individual psychotherapy, insight oriented, behavior modifying an	Inpatient Services	Professional
90816	Include	Individual psychotherapy, insight oriented, behavior modifying an	Inpatient Services	Professional
W2102	Include	Methadone/LAAM administration (take home one dose per day)	Medical Services	Medication Services
W2101	Include	Methadone/LAAM administration (single dose one per day)	Medical Services	Medication Services
W2100	Include	Psychotropic medication, adjustment and monitoring (15 min.)	Medical Services	Medical Management

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
T1003	Include	LPN Services, up to 15 minutes	Medical Services	Medical Management
T1002	Include	RN services, up to 15 minutes	Medical Services	Medical Management
J3410	Include	Injection, Hydroxyzine HCL, up to 25 mg	Medical Services	Medication Services
J2794	Include	Risperidone Injection, long lasting 0.5 MG	Medical Services	Medication Services
J2680	Include	Injection, fluphenazine decanoate, up to 25 mg.	Medical Services	Medication Services
J1631	Include	Injection, Haloperidol decanoate, per 50 mg.	Medical Services	Medication Services
J1630	Include	Injection, Haloperidol, up to 5 mg	Medical Services	Medication Services
J1200	Include	Injection, Diphenhydramine HCL, up to 50 mg	Medical Services	Medication Services
J0515	Include	Injection, Benztropine Mesylate, per 1mg	Medical Services	Medication Services
H2010	Include	Comprehensive medication services, per 15 minutes	Medical Services	Medication Services
H0020	Include	Alcohol and/or drug services; methadone administration and/or ser	Medical Services	Medication Services
99355	Include	Prolonged physician service in the office or other outpatient set	Medical Services	Medical Management
99354	Include	Prolonged physician service in the office or other outpatient set	Medical Services	Medical Management
99350	Include	Home visit for the evaluation and management of an established pa	Medical Services	Medical Management
99349	Include	Home visit for the evaluation and management of an established pa	Medical Services	Medical Management
99348	Include	Home visit for the evaluation and management of an established pa	Medical Services	Medical Management
99347	Include	Home visit for the evaluation and management of an established pa	Medical Services	Medical Management
99345	Include	Home visit for the evaluation and management of a new patient, wh	Medical Services	Medical Management
99344	Include	Home visit for the evaluation and management of a new patient, wh	Medical Services	Medical Management
99343	Include	Home visit for the evaluation and management of a new patient whi	Medical Services	Medical Management
99342	Include	Home visit for the evaluation and management of a new patient whi	Medical Services	Medical Management
99341	Include	Home visit for the evaluation and management of a new patient whi	Medical Services	Medical Management
99333	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99332	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99331	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99323	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99322	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99321	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99303	Include	Evaluation and management of a new or established patient involvi	Medical Services	Medical Management
99302	Include	Evaluation and management of a new or established patient involvi	Medical Services	Medical Management
99301	Include	Evaluation and management of a new or established patient involvi	Medical Services	Medical Management
99215	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99214	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99213	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99212	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99211	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
99205	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99204	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99203	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99202	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
99201	Include	Office or other outpatient visit for the evaluation and managemen	Medical Services	Medical Management
90862	Include	Pharmacologic management, including prescription, use, and review	Medical Services	Medical Management
90815	Include	Individual psychotherapy, interactive, using play equipment, phys	Medical Services	Medical Management
90813	Include	Individual psychotherapy, interactive, using play equipment, phys	Medical Services	Medical Management
90811	Include	Individual psychotherapy, interactive, using play equipment, phys	Medical Services	Medical Management
90809	Include	Individual psychotherapy, insight oriented, behavior modifying an	Medical Services	Medical Management
90807	Include	Individual psychotherapy, insight oriented, behavior modifying an	Medical Services	Medical Management
90805	Include	Individual psychotherapy, insight oriented, behavior modifying an	Medical Services	Medical Management
90782	Include	Therapeutic or diagnostic injection (specify material injected);	Medical Services	Medication Services
80102	Include	Drug, confirmation, each procedure	Medical Services	and Medical Imaging
80101	Include	Drug screen; single drug class, each drug class	Medical Services	and Medical Imaging
80100	Include	Drug screen; multiple drug class	Medical Services	and Medical Imaging
00104	Include	Anesthesia for ECT	Medical Services	Medication Services
00104	Include	Anesthesia for ECT	Medical Services	Medication Services
S5110	Include	Home care training, family (family support), per 15 minutes	Prevention Services	Prevention
W4016	Include	Living skills training-extended (1 hour)	Rehabilitation Services	Living Skills Training
W4015	Include	Living skills training-group (per person) (30 min.)	Rehabilitation Services	Living Skills Training
W4006	Include	Living skills training individual (30 min.)	Rehabilitation Services	Living Skills Training
H2017	Include	Psychosocial rehabilitation living skills training services, per	Rehabilitation Services	Living Skills Training
H2014	Include	Skills training and development, per 15 minutes	Rehabilitation Services	Living Skills Training
97532	Include	Development of cognitive skills to improve attention, memory, pro	Rehabilitation Services	Cognitive Rehabilitation
W4052	Include	Level III behavioral health residential facility (per day)	Residential Services	Health Residen
W4051	Include	Level II behavioral health residential facility (per day)	Residential Services	Health Resident
H0019	Include	Behavioral health long-term residential (non-medical, Non-acute),	Residential Services	Health Residen
H0018	Include	Behavioral health short-term residential, without room and board	Residential Services	Health Resident
Z3070	Include	Continuous in-home respite care (per day)	Support Services	Respite Care
Z3060	Include	Short term in-home respite care (60 min.)	Support Services	Respite Care
Z3050	Include	Personal assistance	Support Services	Personal Assistance
W4050	Include	Therapeutic foster care service (per day)	Support Services	Care
W4049	Include	Peer support-group (per person 30 min.)	Support Services	Peer Support
W4048	Include	Peer support-extended (60 min.)	Support Services	Peer Support
W4047	Include	Peer support (30 min.)	Support Services	Peer Support

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
W4046	Include	Family support (30 min.)	Support Services	Family Support
W4045	Include	Personal assistance extended (60 min.)	Support Services	Personal Assistance
W4044	Include	Personal assistance (30 min.)	Support Services	Personal Assistance
T1020	Include	Personal care services, per diem (not for inpatient or residentia	Support Services	Personal Assistance
T1019	Include	Personal care services, per 15 minutes (not for inpatient or resi	Support Services	Personal Assistance
S5151	Include	Unskilled respite care, not hospice, per diem	Support Services	Respite Care
S5150	Include	Unskilled respite care, not hospice, per 15 minutes	Support Services	Respite Care
S5145	Include	Foster care child, per diem	Support Services	Care
S5140	Include	Foster care adult, per diem	Support Services	Care
S2015	Include	Supportive housing assistance	Support Services	Services
H2016	Include	Comprehensive community support services (peer support), per diem	Support Services	Peer Support
H0043	Include	Supported Housing	Support Services	Services
H0038	Include	Self-help/peer services (peer support), per 15 minutes	Support Services	Peer Support
W2351	Include	Office/clinic therapy and counseling-group (per member)(15 min.)	Treatment Services	Counseling, Group
W2350	Include	Office/clinic therapy and counseling-family(15 min.)	Treatment Services	Counseling, Family
W2300	Include	Office/clinic therapy and counseling-individual (15 min.)	Treatment Services	Counseling, Individual
W2152	Include	In-home family therapy/counseling(15 min.)	Treatment Services	Counseling, Family
W2151	Include	In-home individual therapy/counseling	Treatment Services	Counseling, Individual
S6001	Include	Native American traditional healing services (15 minutes)	Treatment Services	Other Professional
H0004	Include	Home, individual behavioral health counseling and therapy, per 15	Treatment Services	Counseling, Individual
H0001	Include	Alcohol and/or drug assessment	Treatment Services	Assessment and
99199	Include	Unlisted special service report	Treatment Services	Other Professional
97781	Include	Acupuncture w stimulation	Treatment Services	Other Professional
97780	Include	Acupuncture w/o stimulation	Treatment Services	Other Professional
90901	Include	Biofeedback training by any modality	Treatment Services	Other Professional
90880	Include	Hypnotherapy	Treatment Services	Counseling, Individual
90876	Include	Individual psychophysiological therapy incorporating biofeedback	Treatment Services	Other Professional
90875	Include	Individual psychophysiological therapy incorporating biofeedback	Treatment Services	Other Professional
90857	Include	Interactive group psychotherapy (per member)	Treatment Services	Counseling, Group
90853	Include	Group psychotherapy (other than of a multiple-family group) (per	Treatment Services	Counseling, Group
90849	Include	Multiple-family group psychotherapy (per family)	Treatment Services	Counseling, Family
90847	Include	family psychotherapy (conjoint psychotherapy, with patient presen	Treatment Services	Counseling, Family
90846	Include	Family psychotherapy (without the patient present)	Treatment Services	Counseling, Family
90845	Include	Medical psychoanalysis-no units specified	Treatment Services	Counseling, Individual
90814	Include	Individual psychotherapy, interactive, using play equipment, phys	Treatment Services	Counseling, Individual
90812	Include	Individual psychotherapy, interactive, using play equipment, phys	Treatment Services	Counseling, Individual

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
90810	Include	Individual psychotherapy, interactive, using play equipment, phys	Treatment Services	Counseling, Individual
90808	Include	Individual psychotherapy, insight oriented, behavior modifying an	Treatment Services	Counseling, Individual
90806	Include	Individual psychotherapy, insight oriented, behavior modifying an	Treatment Services	Counseling, Individual
90804	Include	Individual psychotherapy, insight oriented, behavior modifying an	Treatment Services	Counseling, Individual
90802	Include	Interactive psychiatric diagnostic interview examination using pl	Treatment Services	Assessment and
90801	Include	Psychiatric diagnostic interview examination, unit unspecified.	Treatment Services	Assessment and
S0163	Include	Risperidone Injection, long lasting 12.5 MG	UNKNOWN	UNKNOWN
96101	Include	intellectual abilities, personality and psychopathology	Treatment Services	and
96102	Include	intellectual abilities, personality and psychopathology	Treatment Services	and
96103	Include	intellectual abilities, personality and psychopathology	Treatment Services	and
96116	Include	reasoning and	Treatment Services	and
96118	Include	reasoning and	Treatment Services	and
96119	Include	reasoning and	Treatment Services	and
96120	Include	reasoning and	Treatment Services	and
99304	Include	Initial nursing facility care, per day,	Treatment Services	and
99305	Include	Initial nursing facility care, per day,	Treatment Services	and
99306	Include	Initial nursing facility care, per day,	Treatment Services	and
99307	Include	Subsequent nursing facility care, per day,	Treatment Services	and
99308	Include	Subsequent nursing facility care, per day,	Treatment Services	and
99309	Include	Subsequent nursing facility care, per day,	Treatment Services	and
99310	Include	Subsequent nursing facility care, per day,	Treatment Services	and
99318	Include	Evaluation and management of a patient involving an annual	Treatment Services	and
90772	Include	Therapeutic, prophylactic or diagnostic injection	Medical Services	Medication Services
99304	Include	Initial nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99305	Include	Initial nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99306	Include	Initial nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99307	Include	Subsequent nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99308	Include	Subsequent nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99309	Include	Subsequent nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99310	Include	Subsequent nursing facility care, per day, for the evaluation	Medical Services	Medical Management
99318	Include	Evaluation and management of a patient involving	Medical Services	Medical Management
99324	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99325	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99326	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99327	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99328	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
99334	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99335	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99336	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
99337	Include	Domiciliary or rest home visit for the evaluation and management	Medical Services	Medical Management
S9986	Exclude	Not medically necessary service, pt aware that services not medic	Crisis Intervention Services	Crisis Services
99217	Exclude	Observation care Discharge Day Management	Inpatient Services	Professional
G0001	Exclude	Routine venipuncture or finger/heel/ear stick for collection of s	Medical Services	and Medical Imaging
99499	Exclude	Unlisted evaluation and management service	Medical Services	Medical Management
99359	Exclude	Prolonged evaluation and management service before and/or after d	Medical Services	Medical Management
99358	Exclude	Prolonged evaluation and management service before and/or after d	Medical Services	Medical Management
99316	Exclude	Nursing facility discharge day management, more than 30 minutes.	Medical Services	Medical Management
99315	Exclude	Nursing facility discharge day management, 30 minutes or less	Medical Services	Medical Management
99313	Exclude	Subsequent nursing facility care, per day, for the evaluation and	Medical Services	Medical Management
99312	Exclude	Subsequent nursing facility care, per day, for the evaluation and	Medical Services	Medical Management
99311	Exclude	Subsequent nursing facility care, per day, for the evaluation and	Medical Services	Medical Management
95819	Exclude	Electroencephalogram (EEG) including recording awake and asleep,	Medical Services	and Medical Imaging
93042	Exclude	Rhythm ECG, one to three leads, interpretation and report only	Medical Services	and Medical Imaging
93041	Exclude	Rhythm ECG, one to three leads, tracing only	Medical Services	and Medical Imaging
93040	Exclude	Rhythm ECG, one to three leads, with interpretation and report	Medical Services	and Medical Imaging
93010	Exclude	Electrocardiogram, routine ECG with at least 12 leads; interpreta	Medical Services	and Medical Imaging
93005	Exclude	Electrocardiogram, routine ECG with at least 12 leads; without in	Medical Services	and Medical Imaging
93000	Exclude	Electrocardiogram, routine ECG with at least 12 leads; with inter	Medical Services	and Medical Imaging
90871	Exclude	Electroconvulsive therapy (includes necessary monitoring); multi	Medical Services	Therapy
90870	Exclude	Electroconvulsive therapy (includes necessary monitoring); singl	Medical Services	Therapy
87391	Exclude	Infectious agent antigen detection by enzyme immunoassay techniqu	Medical Services	and Medical Imaging
87390	Exclude	Infectious agent antigen detection by enzyme immunoassay techniqu	Medical Services	and Medical Imaging
86703	Exclude	Antibody; HIV-1 and HIV-2, single assay	Medical Services	and Medical Imaging
86702	Exclude	Antibody; HIV-2	Medical Services	and Medical Imaging
86701	Exclude	Antibody; HIV-1	Medical Services	and Medical Imaging
86689	Exclude	Antibody; HTLV or HIV antibody, confirmatory test (eg, WES)	Medical Services	and Medical Imaging
86593	Exclude	Syphilis test; quantitative	Medical Services	and Medical Imaging
86592	Exclude	Syphilis test; qualitative (eg, VDRL, RPR, ART)	Medical Services	and Medical Imaging
86585	Exclude	TB test tine test	Medical Services	and Medical Imaging
86580	Exclude	TB test (PPD)	Medical Services	and Medical Imaging
85652	Exclude	Sedimentation rate, erythrocyte; automated	Medical Services	and Medical Imaging
85651	Exclude	Sedimentation rate, erythrocyte; non-automated	Medical Services	and Medical Imaging

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
85048	Exclude	White blood cell (WBC) count	Medical Services	and Medical Imaging
85027	Exclude	Blood count; hemogram and platelet count, automated	Medical Services	and Medical Imaging
85025	Exclude	Blood count; hemogram and platelet count, automated, and automate	Medical Services	and Medical Imaging
85018	Exclude	Blood count; hemoglobin, colorimetric	Medical Services	and Medical Imaging
85014	Exclude	Blood count; hematocrit	Medical Services	and Medical Imaging
85013	Exclude	Blood count; spun microhematocrit	Medical Services	and Medical Imaging
85009	Exclude	Blood count; differential WBC count, buffy coat	Medical Services	and Medical Imaging
85008	Exclude	Blood count; manual blood smear examination without differential	Medical Services	and Medical Imaging
85007	Exclude	Blood count; manual differential WBC count (inc. RBC morphology a	Medical Services	and Medical Imaging
84703	Exclude	Gonadotropin, chorionic (HCG), qualitative	Medical Services	and Medical Imaging
84520	Exclude	Urea nitrogen, blood (BUN); quantitative	Medical Services	and Medical Imaging
84443	Exclude	Thyroid stimulating hormone(TSH), RIA or EIA	Medical Services	and Medical Imaging
84439	Exclude	Thyroxine; free	Medical Services	and Medical Imaging
84436	Exclude	Thyroxine; total	Medical Services	and Medical Imaging
84146	Exclude	Prolactin	Medical Services	and Medical Imaging
84132	Exclude	Potassium; blood	Medical Services	and Medical Imaging
84022	Exclude	Phenothiazines	Medical Services	and Medical Imaging
83992	Exclude	Phencyclidine (PCP)	Medical Services	and Medical Imaging
83925	Exclude	Opiates (morphine, meperidine)	Medical Services	and Medical Imaging
83840	Exclude	Methadone	Medical Services	and Medical Imaging
82977	Exclude	Glutamyltransferase (GGT)	Medical Services	and Medical Imaging
82948	Exclude	Glucose, blood, reagent strip	Medical Services	and Medical Imaging
82947	Exclude	Glucose, quantitative, blood (except reagent strip)	Medical Services	and Medical Imaging
82746	Exclude	Folic Acid	Medical Services	and Medical Imaging
82742	Exclude	Flurazepam	Medical Services	and Medical Imaging
82607	Exclude	Cyanocobalamin (Vitamin B12)	Medical Services	and Medical Imaging
82575	Exclude	Creatinine clearance	Medical Services	and Medical Imaging
82570	Exclude	Creatinine (other than serum)	Medical Services	and Medical Imaging
82565	Exclude	Creatinine; blood	Medical Services	and Medical Imaging
82533	Exclude	Cortisol, total	Medical Services	and Medical Imaging
82530	Exclude	Cortisol, free	Medical Services	and Medical Imaging
82520	Exclude	Cocaine, quantitative	Medical Services	and Medical Imaging
82465	Exclude	Cholesterol, serum or whole blood, total	Medical Services	and Medical Imaging
82382	Exclude	Urinary catecholamines	Medical Services	and Medical Imaging
82205	Exclude	Barbiturate, not elsewhere specified	Medical Services	and Medical Imaging
82145	Exclude	Amphetamine or methamphetamine, chemical, quantitative	Medical Services	and Medical Imaging

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
82075	Exclude	Alcohol (ethanol), breath	Medical Services	and Medical Imaging
82055	Exclude	Alcohol (ethanol), blood, urine	Medical Services	and Medical Imaging
81050	Exclude	Volume measurement for timed collection, each	Medical Services	and Medical Imaging
81025	Exclude	Urine pregnancy test, by visual color comparison methods	Medical Services	and Medical Imaging
81005	Exclude	Urinalysis; qualitative or semiquantitative, except immunoassays	Medical Services	and Medical Imaging
81003	Exclude	Urinalysis, without microscopy	Medical Services	and Medical Imaging
81002	Exclude	Urinalysis, by dip stick or tablet reagent for filirubin, glucose	Medical Services	and Medical Imaging
81001	Exclude	Urinalysis, by dip stick or tablet reagent for filirubin, glucose	Medical Services	and Medical Imaging
81000	Exclude	Urinalysis, by dip stick or tablet reagent for filirubin, glucose	Medical Services	and Medical Imaging
80420	Exclude	Dexamethasone suppression panel, 48 hour	Medical Services	and Medical Imaging
80299	Exclude	Quantitation of psychotropic drug, NOS	Medical Services	and Medical Imaging
80182	Exclude	Nortriptyline	Medical Services	and Medical Imaging
80178	Exclude	Lithium	Medical Services	and Medical Imaging
80174	Exclude	Imipramine	Medical Services	and Medical Imaging
80166	Exclude	Doxepin	Medical Services	and Medical Imaging
80164	Exclude	Valproic Acid	Medical Services	and Medical Imaging
80160	Exclude	Desipramine	Medical Services	and Medical Imaging
80156	Exclude	Carbamazepine	Medical Services	and Medical Imaging
80154	Exclude	Benzodiazepines	Medical Services	and Medical Imaging
80152	Exclude	Amitriptyline	Medical Services	and Medical Imaging
80076	Exclude	Hepatic function panel	Medical Services	and Medical Imaging
80061	Exclude	Lipid Panel	Medical Services	and Medical Imaging
80053	Exclude	Comprehensive metabolic panel	Medical Services	and Medical Imaging
80051	Exclude	Electrolyte panel	Medical Services	and Medical Imaging
80050	Exclude	General health panel	Medical Services	and Medical Imaging
80048	Exclude	Basic metabolic panel	Medical Services	and Medical Imaging
70553	Exclude	Magnetic resonance imaging, brain; without contrast material, fol	Medical Services	and Medical Imaging
70552	Exclude	Magnetic resonance imaging, brain; with contrast material	Medical Services	and Medical Imaging
70551	Exclude	Magnetic resonance imaging, brain; without contrast material	Medical Services	and Medical Imaging
70470	Exclude	Computerized axial tomography, head or brain: w/o contrast materi	Medical Services	and Medical Imaging
70460	Exclude	Computerized axial tomography, head or brain: with contrast mater	Medical Services	and Medical Imaging
70450	Exclude	Radiology/brain Tomography W/o	Medical Services	and Medical Imaging
W4031	Exclude	Job coaching and employment support (15 min.)	Rehabilitation Services	Supported Employment
W4030	Exclude	Pre-job training education and development (15 min.)	Rehabilitation Services	Supported Employment
W4020	Exclude	Health promotion (per person) (30 min.)	Rehabilitation Services	Health Promotion
H2027	Exclude	Psychoeducational service (pre-job training and development), per	Rehabilitation Services	Supported Employment

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
H2026	Exclude	Ongoing support to maintain employment, per diem	Rehabilitation Services	Supported Employment
H2025	Exclude	Ongoing support to maintain employment, per 15 minutes	Rehabilitation Services	Supported Employment
H0034	Exclude	(Health promotion) medication training and support, per 15 minute	Rehabilitation Services	Health Promotion
H0025	Exclude	Behavioral health prevention/promotion education service (service	Rehabilitation Services	Health Promotion
S2000	Exclude	Room and Board	Residential Services	Room and Board
H0046	Exclude	Mental Health Services NOS	Residential Services	Room and Board
Z3724	Exclude	Taxicab, per mile	Support Services	Transportation
Z3723	Exclude	Urban, wheelchair van, per mile	Support Services	Transportation
Z3722	Exclude	Urban stretcher van, per mile	Support Services	Transportation
Z3721	Exclude	Urban stretcher van, base rate	Support Services	Transportation
Z3717	Exclude	Non-ambulance waiting time (per half hour)	Support Services	Transportation
Z3715	Exclude	Helicopter taxi, non-emergency,	Support Services	Transportation
Z3655	Exclude	Non-covered ground ambulance mileage, per mile (miles traveled be	Support Services	Transportation
Z3648	Exclude	Ambulatory van, rural base rate	Support Services	Transportation
Z3647	Exclude	Rural, stretcher van, per mile	Support Services	Transportation
Z3646	Exclude	Rural, stretcher van, base rate	Support Services	Transportation
Z3645	Exclude	Rural, wheelchair van, per mile	Support Services	Transportation
Z3644	Exclude	Rural, wheelchair van, base rate	Support Services	Transportation
Z3643	Exclude	Rural, non-emergency transport coach van, per mile	Support Services	Transportation
Z3621	Exclude	Ambulatory van, urban base rate	Support Services	Transportation
Z3620	Exclude	Urban non-emergency transport, coach van, per mile	Support Services	Transportation
Z3610	Exclude	Private vehicle, per mile	Support Services	Transportation
Z2999	Exclude	Special transport	Support Services	Transportation
W4043	Exclude	Case management out of office (15 min.)	Support Services	Case Management
W4042	Exclude	Case management office (15 min.)	Support Services	Case Management
W4041	Exclude	Case management-behavioral health professional-out of office (15	Support Services	Case Management
W4040	Exclude	Case management-behavioral health professional-office (15 min.)	Support Services	Case Management
T2049	Exclude	Non emergency transport, stretcher van	Support Services	Transportation
T2007	Exclude	Transportation waiting time, air ambulance and non-emergency vehi	Support Services	Transportation
T2005	Exclude	Non-emergency transportation, non-ambulatory stretcher van	Support Services	Transportation
T2003	Exclude	Non-emergency transportation; encounter/trip	Support Services	Transportation
T1016	Exclude	Office case management by behavioral health professional, each 15	Support Services	Case Management
T1013	Exclude	Sign language or oral interpretive services	Support Services	Interpreter Services
S7001	Exclude	Interpreter services to assist clients	Support Services	Interpreter Services
S6000	Exclude	Flex Funded Service	Support Services	Flex Fund Services
S0215	Exclude	Non-emergency transportation mileage, per mile	Support Services	Transportation

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
S0209	Exclude	Wheelchair van mileage, per mile	Support Services	Transportation
A0999	Exclude	Unlisted ambulance service . Determine if an alternative nationa	Support Services	Transportation
A0888	Exclude	Non-covered ambulance mileage, per mile (E.G. for miles traveled)	Support Services	Transportation
A0436	Exclude	Rotary wing air mileage, per statute mile	Support Services	Transportation
A0435	Exclude	Fixed wing air mileage, per statute mile	Support Services	Transportation
A0434	Exclude	Specialty care transport (SCT)	Support Services	Transportation
A0431	Exclude	Ambulance service, conventional air services, transport, one way	Support Services	Transportation
A0430	Exclude	Ambulance service, conventional air services, transport, one way	Support Services	Transportation
A0429	Exclude	Ambulance service; basic life support base rate, emergent. transp	Support Services	Transportation
A0428	Exclude	Ambulance service; basic life support base rate, non-emergency tr	Support Services	Transportation
A0427	Exclude	Ambulance service, advanced life support, emergency transport, le	Support Services	Transportation
A0426	Exclude	Ambulance service, advanced life support, non-emergent. transport	Support Services	Transportation
A0425	Exclude	Ground mileage, per mile	Support Services	Transportation
A0422	Exclude	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaini	Support Services	Transportation
A0420	Exclude	Ambulance waiting time (ALS or BLS), 1/2 hour increments	Support Services	Transportation
A0398	Exclude	ALS routine disposable supplies	Support Services	Transportation
A0382	Exclude	BLS routine disposable supplies	Support Services	Transportation
A0210	Exclude	Non-emergency transport: ancillary services-meals-escort	Support Services	Transportation
A0200	Exclude	Non-emergency transport: ancillary services-lodging -escort	Support Services	Transportation
A0190	Exclude	Non-emergency transport: ancillary services-meals-recipient	Support Services	Transportation
A0180	Exclude	Non-emergency transport: ancillary services-lodging-recipient	Support Services	Transportation
A0170	Exclude	Non-emergency transport: ancillary services-parking fees, tolls,	Support Services	Transportation
A0160	Exclude	Non-emergency transport; mile - case worker or social worker	Support Services	Transportation
A0140	Exclude	Non-emergency transport; and air travel (private or commercial) i	Support Services	Transportation
A0130	Exclude	Non-emergency transport; wheel-chair van., base rate	Support Services	Transportation
A0120	Exclude	Non-emergency transportation: mini-bus, mountain area transports	Support Services	Transportation
A0110	Exclude	Non-emergency transport via intra- or interstate carrier	Support Services	Transportation
A0100	Exclude	Non-emergency transport; taxi, intra-city, base rate	Support Services	Transportation
A0090	Exclude	Non-emergency transportation, per mile, vehicle provided by indiv	Support Services	Transportation
99373	Exclude	Telephone call, complex or lengthy (eg, lengthy counseling sessio	Support Services	Case Management
99372	Exclude	Telephone call, intermediate (eg, to provide advice to an establi	Support Services	Case Management
99371	Exclude	Telephone call by a physician or for consultation or medical mana	Support Services	Case Management
99362	Exclude	Medical conference by a physician with interdisciplinary team of	Support Services	Case Management
99361	Exclude	Medical conference by a physician with interdisciplinary team of	Support Services	Case Management
90889	Exclude	Preparation of report of patient's psychiatric status, history, t	Support Services	Case Management
90887	Exclude	Interpretation or explanation of results of psychiatric, other me	Support Services	Case Management

Attachment A

Routine Appointments for Ongoing Services Within 23 Days of Initial Assessment

(Service Procedure Codes Included or Excluded as Service on Same Day as Assessment)

P_CODE	Include/Exclude	PROCEDURE_NAME	CAT_DESCRIPTION	SUBCAT_DESCRIPTION
90882	Exclude	Environmental intervention for medical management purposes on a p	Support Services	Case Management
S9000	Exclude	Auricular Acupuncture	Treatment Services	Other Professional
W4005	Exclude	Assessment comprehensive(30 min.)	Treatment Services	Assessment and
W4003	Exclude	Screening(15 min.)	Treatment Services	Assessment and
W4002	Exclude	Assessment rehabilitative employment support (30 min.)	Treatment Services	Assessment and
W4001	Exclude	Assessment general(30 min.)	Treatment Services	Assessment and
H0031	Exclude	Mental health assessment, by non-physician 30 minute increments	Treatment Services	Assessment and
H0002	Exclude	Behavioral health screening to determine eligibility for admissio	Treatment Services	Assessment and
99275	Exclude	Confirmatory consultation for a new or established patient, which	Treatment Services	Assessment and
99274	Exclude	Confirmatory consultation for a new or established patient, which	Treatment Services	Assessment and
99273	Exclude	Confirmatory consultation for a new or established patient, which	Treatment Services	Assessment and
99272	Exclude	Confirmatory consultation for a new or established patient, which	Treatment Services	Assessment and
99271	Exclude	Confirmatory consultation for a new or established patient, which	Treatment Services	Assessment and
99245	Exclude	Office consultation for a new or established patient, which requi	Treatment Services	Assessment and
99244	Exclude	Office consultation for a new or established patient, which requi	Treatment Services	Assessment and
99243	Exclude	Office consultation for a new or established patient, which requi	Treatment Services	Assessment and
99242	Exclude	Office consultation for a new or established patient, which requi	Treatment Services	Assessment and
99241	Exclude	Office consultation for a new or established patient, which requi	Treatment Services	Assessment and
96117	Exclude	Neuropsychological testing battery (eg, Halstead-Reitan, Luria, W	Treatment Services	Assessment and
96115	Exclude	Neurobehavioral status exam (clinical assessment of thinking, rea	Treatment Services	Assessment and
96111	Exclude	Developmental testing: extended (includes assessment of motor, l	Treatment Services	Assessment and
96110	Exclude	Developmental testing; limited (eg, developmental screening test	Treatment Services	Assessment and
96100	Exclude	Psychological testing (includes psychodiagnostic assessment of pe	Treatment Services	Assessment and
90899	Exclude	Unlisted psychiatric service or procedure	Treatment Services	Other Professional
90885	Exclude	Psychiatric evaluation of hospital records, other psychiatric rep	Treatment Services	Consultation,
36415	Exclude	Collection of venous blood by venipuncture	Laboratory, Radiology and	Medical Management

Attachment B

Access to Care: Assessment to First Service
Minimum Performance Standards for Usable Data

Timeframe	How Measured	Minimum Performance Standard	Benchmark Performance Standard
Quarter 1 (July 1 – September 30)	Compare the number of members with an effective enrollment date during Quarter 1 (July - September) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (July through September).	35%	70%
Quarter 2 (October 1 – December 31)	Compare the number of members with an effective enrollment date during the reporting quarter (October - December) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (October - December). Refresh the encounter data for the previous reporting quarter and restate Quarter 1 (July – September)	45%	75%
Quarter 3 (January 1 – March 31)	Compare the number of members with an effective enrollment date during the reporting quarter (January - March) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (January - March). Refresh the encounter data for the previous two reporting quarters and restate Quarter 1 (July – September) & Quarter 2 (October – December)	55%	80%
Quarter 4 (April 1 – June 30)	Compare the number of members with an effective enrollment date during the reporting quarter (April - June) with encounter data for an assessment, to the number of members with an effective enrollment date during the reporting quarter (April - June). Refresh the encounter data for the previous three reporting quarters and restate Quarter 1 (July – September), Quarter 2 (October – December), and Quarter 3 (January – March)	65%	85%
Annual Summary Annual summary FY 2006 due by March 1, 2007	Annual Fiscal Year Summary. Compare the number of members with an effective enrollment date during each of the 4 quarters of FY06 (July 1, 2005 – June 30, 2006) with encounter data for an assessment, to the number of members with an effective enrollment date during each of the 4 reporting quarters (July 1, 2005 – June 30, 2006).	85%	85%

COMPLAINT REPORTING

DESCRIPTION

Report of all complaints pertaining to Title XIX/XXI Children and Adult and Non Title XIX SMI Adults. Complaints may be received by the RBHA and ADHS/DBHS Customer Service. Complaints may be lodged by eligible/enrolled members, family members, providers and community stakeholders.

ADHS/DBHS defines a complaint as an expression of dissatisfaction with any aspect of care, other than the appeal of actions.

METHODOLOGY

Population
Title XIX/XXI children and adults; Non Title XIX SMI Adults.

Reporting Frequency
Quarterly (the 30th day following the end of the quarter).

Reporting Format
See 'Electronic Quality Management Report Template'.

Data Source
RBHA Submitted Complaint Logs to Sherman Server
Electronic Quality Management Report

Calculation of Rate per 1000

$$\frac{\text{Total Number of Complaints}}{\text{Total Number Enrolled}} \times 1000$$

T/RBHA Reporting Requirements
Complaint data is stratified by:

- Population
- Program Type

- Complaint Category/Sub-category
- Covered Service Category/Sub-category
- Treatment Setting
- Resolution

Refer to ADHS Policy GA 3.6, Complaint Resolution for data stratification definitions. Complaint data logs shall adhere to Attachment A, Complaint Log Data Layout Specifications.

QUALITY CONTROL

ADHS/DBHS reviews RBHA complaint logs for logic and consistency with ADHS/DBHS mandated complaint data specifications.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA compliant. All data is aggregated at the RBHA level, and is not presented at an individual member level.

Specifications

Complaint Log
Data Layout

Column Format

Field Name	Definition	Format	Remarks
Client Last Name		Text: 15 characters	
Client First Name		Text: 10 characters	
Complaint Date	The date the RBHA was contacted with the complaint.	Date: yyyymmdd (8 characters)	
Title XIX/XXI Eligibility	Status of the member's Title XIX/XXI eligibility at the time of the complaint.	Text: (1 character) Y/N	Y = Yes, N = No
Complaint Description		Text. Defined categories should be used.	Standard categories and sub-categories created by workgroup should be used.
Complaint Source	Person or entity making the complaint.	Text. Defined categories should be used.	Standard categories created by workgroup should be used.
Communication Needs	Any identified communication needs, such as the need for a translator, TTY phone, etc…	Text. Defined categories should be used.	Standard categories created by workgroup should be used. Extra categories can be added to meet RBHA needs.
Resolution Reached			Standard categories created by workgroup should be used.
Length of time (for resolution)	The length of time, in days, that it took to resolve the complaint from the time of the call to closure.	Text	Count the number of days from call to closure.
Extension Granted	Complaints should be resolved within specified time frames; if not, an extension must be granted.	Text: (1 character) Y/N	Y = Yes, N = No
Covered Service Category	Covered service related to complaint.	Text: (5 characters) Codes from Covered Services Guide used if applicable.	Refer to Covered Services Guide for Valid Values.
Treatment Setting	Treatment setting related to complaint.	Text	Standard categories created by workgroup should be used. Extra categories can be added to meet RBHA needs.
Program Type	Child, SMI, GMH, SA, SED	Text: C, S, M, G, Z (1 character)	C = Child, S = SMI, M = GMH, G = SA, Z = SED

FOLLOW UP SERVICE AFTER DISCHARGE FROM A FACILITY

DESCRIPTION

Provision of a mental health service within 30 days of discharge from a facility.

PERFORMANCE STANDARD

Minimum: 79%
Goal: 90%

The minimum performance standard must be met quarterly by each GSA, for both the Child and Adult populations.

METHODOLOGY

Population
All Title XIX/XXI eligible children and adults discharged from a facility during the reporting period.

Reporting Frequency
Data is collected monthly by the RBHA and reported to ADHS quarterly utilizing the Quarterly UM Report Template.

Data Source
RBHA facility tracking logs, encounter data.

Calculation
A. Determine TXIX/XXI behavioral health recipients discharged from a facility during the month.
B. Align discharged behavioral health recipients with HEDIS specifications for "eligible" behavioral health recipients.
C. Behavioral health recipients are not included in the calculation if:
   - <6 years old
   - Disenrolled within 30 days of discharge
   - Were admitted to a facility within 30 days of discharge. These discharges are excluded because the subsequent admission may prevent an ambulatory follow-up visit from taking place. Table will be duplicated on behavioral health recipients if they had multiple discharges occurring 30 days or more of each other. If multiple discharges occur within 30 days of each other, use only the last discharge.
D. Subtract date of follow up service from date of discharge to calculate the number of days after discharge the service was provided.

E. See Attachment A for lists of Revenue Codes and Encounter Service Codes that qualify as "valid" codes.
F. The percentage of behavioral health recipients who received a service within 7 days of discharge is calculated.
   Numerator: Number of Discharged behavioral health recipients with a follow up service encounter within 7 days of discharge.
   Denominator: Number of Discharged behavioral health recipients.
G. The percentage of behavioral health recipients who received a service within 30 days of discharge is calculated.
   Numerator: Number of Discharged behavioral health recipients with a follow up service encounter within 30 days of discharge.
   Denominator: Number of Discharged behavioral health recipients.

QUALITY CONTROL

The accuracy and completeness of encounter data submitted by the RBHAs to ADHS/DBHS' Client Information System (CIS) is ensured through encounter validation studies conducted by the Office of Program Support. RBHAs found in non-compliance are subject to sanctions.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level. Data collected for the Follow up Service after Discharge measure is used only for this project.

Attachment A

Follow-up Service After Discharge Performance Measure

Revenue codes to be included: 513, 900, 901, 909-916, 961.

Encounter Service Codes for Follow-up Service:

90804	90806	90808	90810	90812
90814	90845	90853	90857	90847
90849	90801	90802	90885	99243
99244	99245	90805	90807	90809
90811	90813	90815	90862	99201
99202	99203	99204	99205	99211
99212	99213	99214	99215	99341
99342	99343	99344	99345	99347
99348	99349	99350	90870	90871
90816	90817	90818	90819	90821
90822	90823	90824	90826	90827
90828	90829	99241	99242	H0004*
90782	H0020	H2010	H2019	H2020
80299	J0515	J1200	J1630	J1631
J2680	J3410	S0163	T1002	T1016
H0025	H0034	H0036	H0037	H0038
H2012	H2014	H2015	H2016	H2017
H2025	H2026	H2027	T1003	T1019
T1020				

AVERAGE LENGTH OF STAY

DESCRIPTION

For behavioral health recipients admitted to a facility, the average number of days they remain in the facility.

METHODOLOGY

Population
The population includes all TXIX/TXXI-eligible adults and children who were admitted to and discharged from a facility during the measurement period.

Reporting Frequency
Data is collected monthly by the RBHA and reported to ADHS quarterly utilizing the Quarterly UM Report Template.

Data Source
RBHA inpatient tracking.

Calculation

1. For each behavioral health recipient, the Length of Stay (LOS) is based on the number of days from the date the behavioral health recipient was admitted into the facility to the date that the behavioral health recipient was discharged from that facility.

The formula for this process is as follows:

Length of Stay (LOS) = Discharge Date – Admission Date

The Average Length of Stay is calculated as follows:

1. Add the Lengths of Stay for all behavioral health recipients discharged from facilities to obtain the Total Length of Stay.
2. Count all records showing a discharge from a facility to obtain the Total Number of Discharges.
3. Divide the Total Length of Stay by the Total Number of Discharges to obtain the Average Length of Stay.

The formula for this process is as follows:

$$\frac{\text{Total Length of Stay}}{\text{Total Number of Discharges}} = \textbf{Average Length of Stay}$$

Data Reporting
Data is reported separately for each GSA by adult, child, and treatment setting.

QUALITY CONTROL

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS upon request.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

READMISSION RATE

DESCRIPTION

The percentage of behavioral health recipients discharged from a facility and readmitted within 30 days.

METHODOLOGY

Population
TXIX/TXXI eligible adults and children.

Reporting Frequency
Data is collected monthly by the RBHA and reported to ADHS quarterly utilizing the Quarterly UM Report Template. All behavioral health recipients discharged during the previous month are assessed for a readmission within 30 days of discharge.

Data Source
RBHA facility tracking databases.

Calculation
A readmission occurs when a behavioral health recipient is admitted to the same or different level of care within 30 days of discharge from a facility. The readmission rate applies to the treatment setting from which the behavioral health recipient was discharged.

The Readmits table identifies readmissions during the reporting period, using the following methodology:

1. Identify individuals who were in facility care for the reporting month.
2. Identify the behavioral health recipients discharged during the previous month.
3. Put these two groups of records together to provide the base for identifying readmits.
4. Sort the records by Client ID and Admission Date.
5. For behavioral health recipients with at least two records in this sorted list, examine the Discharge Date (in the END_DT field) of the first record and the Admission Date (in the ADMISSION_DT field) of the second record.
6. Subtract the Admission Date of the second record from the Discharge Date of the first record and examine the result to see if it qualifies as a readmission.
7. If the result is 0 or 1, the result represents a transfer and not a readmission. A transfer occurs when a behavioral health recipient admitted the same day or the next day following a discharge.

8. If the result is in the 2 to 30 range, it qualifies as a readmission. These are behavioral health recipients admitted within 30 days of a discharge.
9. If the result is more than 30, it does not qualify as a readmission; it is considered to be a separate admission.
10. Continue in this manner through the sorted list.

Example of a transfer:
Discharge Date 6/16/2006 followed by Admit Date 6/16/2006 or 6/17/2006

Example of a readmission:
Discharge Date 6/16/2006 followed by Admit Date 6/18/2006

The methodology for the readmission rate is to take the total number of inpatient encounters that were found to be readmissions within 30 days and divide it by the total number of discharge inpatient encounters. The result is the Percent of Readmission and the formula for it is as follows:

Number of behavioral health recipients Readmitted within 30 Days X 100 = **Percent of Readmission**
Number of Discharges

QUALITY CONTROL

RBHAs are responsible for ensuring the accuracy of the information provided and may be required to submit verification to ADHS upon request.

ERRORS

An error is defined as being encounters in the sorted readmission base table where the Discharge Date of a behavioral health recipient's discharge inpatient encounter is greater than or equal to the Admission Date of the next inpatient encounter for that behavioral health recipient in the sorted table.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

SHOWING REPORT

DESCRIPTION

Each RBHA must submit a Quarterly Showing Certification signed by their Medical Director or CEO to ADHS as specified in the ADHS/RBHA contract. The report is due to ADHS by the **10th day of the month following the end of each reporting quarter**. The Certification page is mailed or faxed to:

Office of Medical Management
Bureau of Quality Management Operations
Division of Behavioral Health Services
Arizona Department of Health Services
150 N. 18th Avenue, Suite 240
Phoenix, Arizona 85007
Fax: (602) 364-4749

ADHS must report the findings of the Showing Reports to AHCCCS by the 17th day of the month following the end of each quarter.

METHODOLOGY

Population
The population includes all Title XIX or XXI-eligible children and adults who were in a Level 1 facility during the reporting quarter.

Data Reporting
The Showing Report findings submitted by ADHS to AHCCCS must include the following:

- A copy of the signed Certification page for each RBHA.
- A cover letter addressed to AHCCCS, signed by the ADHS/DBHS Deputy Director and Medical Director.

Copies of the cover letter to AHCCCS and Showing Report Findings are mailed to each RBHA Executive Director.

QUALITY CONTROL

A document detailing the requirements for the RBHAs submission of the Showing Report to ADHS is attached to the end of this document.

A Showing Report checklist for ADHS is attached to the end of this document.

ERROR RATE

All errors must be corrected prior to submission to AHCCCS. An error is defined as an omission or inaccurate information in any required field.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

Arizona Department of Health Services
SHOWING REPORT CHECKLIST

T/RBHA: _____ Reporting Quarter: _____
Date: _____

Issue	OK? (Y/N)	Comments
T/RBHA Submission		
1. Attestation page is received		
2. Standardized Attestation form is used		
3. Attestation page has correct dates reflecting current reporting quarter		
4. Attestation page is properly signed with signature dated		
5. Run Copy of records sent by T/RBHA		
Clerical		
1. AHCCCS letter is signed by DBHS Deputy Director and Medical Director		

Show_check.doc

INCIDENT/ACCIDENT/DEATH TRENDING REPORT AND SECLUSION AND RESTRAINT REPORTING

DESCRIPTION

1. Incidents, accidents and deaths for all behavioral health recipients

2. Seclusion and restraint for behavioral health recipients in Licensed Level I Facilities

METHODOLOGY

Population

1. Incidents/Accidents/Deaths
   All enrolled adults and children (GMH, SA, SMI, C/A) receiving behavioral health services through a T/RBHA who were involved in a reported incident, accident, or death during the reporting period.

2. Seclusion and Restraint
   All enrolled adults and children (GMH, SA, SMI, C/A) receiving behavioral health services through a T/RBHA, who were in Level I facilities, and were secluded and/or restrained during the reporting period.

Reporting Frequency

Quarterly (the 30th day following the end of the quarter).

Data Reporting

1. Incidents/Accidents/Deaths
   - Number of incidents, accidents, deaths for the reporting period by
     - Type
     - Cause
     - Behavioral Health Category (GMH, SA, SMI, C/A)

   - Percent of incidents, accidents, deaths for the reporting period by
     - Type
     - Cause
     - Behavioral health category

     Numerator = Total number of incidents, accidents, deaths for the reporting quarter
     Denominator = Total number enrolled in T/RBHA

- Trending of incidents, accidents, death by
  - Type
  - Cause
  - Behavioral Health Category
  - Per 1000 enrolled

- Data analysis to include contributing factors and root cause analyses when indicated.

2. Seclusion and Restraint
   - Percent of Behavioral Health Recipients Secluded (unduplicated)

     Numerator = Total number of unduplicated behavioral health recipients who were secluded at least once during the reporting period X 100
     Denominator = Total number of unduplicated behavioral health recipients who were inpatient during the reporting period

   - Percent of Behavioral Health Recipients with Multiple Seclusion Episodes

     Numerator = Total number of behavioral health recipients who were secluded 2 or more times within 24 hours during the reporting period X 100
     Denominator = Total number of behavioral health recipients who were inpatient during the reporting period.

   - Average Time in Seclusion

     Numerator = Total number of minutes that all behavioral health recipients spent in seclusion.
     Denominator = Total number of seclusions.

   - Compliance with Seclusion Timeframes (see AAC R9-20-602.C5):

     Numerator = Number of restraint occurrences compliant with seclusion timeframes.
     Denominator = Total number of seclusions.

   - Percent of Behavioral Health Recipients Restrained (unduplicated)

     Numerator = Total number of unduplicated behavioral health recipients who were restrained at least once during the reporting period X 100.
     Denominator = Total number of unduplicated behavioral health recipients who were inpatient during the reporting period.

- Percent of Behavioral Health Recipients with Multiple Restraint Episodes

  Numerator = Total number of behavioral health recipients who were restrained 2 or more times within 24 hours during the reporting period X 100.
  Denominator = Total number of behavioral health recipients who were inpatient during the reporting period.

- Average Time in Restraint

  Numerator = Total number of minutes that all behavioral health recipients spent in restraint.
  Denominator = Total number of restraints.

- Compliance with Restraint Timeframes (see AAC R9-20-602.C5)

  Numerator = Number of restraint occurrences compliant with restraint timeframes.
  Denominator = Total number of restraints.

- Percent of Behavioral Health Recipients Pharmacologically Restrained (unduplicated) by age band and reason for event.

  Numerator = Total number of unduplicated behavioral health recipients pharmacologically restrained at least once during the reporting period X 100.
  Denominator = Total number of unduplicated behavioral health recipients inpatient.

Data Source

1. Incidents/Accidents/Deaths
   T/RBHA Incident Reports; Provider Manual, Section 7.4, PM form 7.4.1.

2. Seclusion and Restraint:
   T/RBHA Incident Reports; Provider Manual Section 7.3, PM form 7.3.1.

Data Collection

1. Incidents/Accidents/Deaths
   Data is collected and reported at the time of the incident.

2. Seclusions and Restraints
   Data is collected and reported at the time of the seclusion and/or restraint.

QUALITY CONTROL

1. Incidents/Accidents/Deaths

   The number of incidents and accidents reported should be consistent with the number of Incident Reports submitted to the T/RBHA. The number of reported deaths will be reviewed against the ADHS/DBHS Morbidity and Mortality database for accuracy in reporting. ADHS/DBHS may conduct periodic data validation activities to monitor for data quality and completeness.

2. Seclusion and Restraint

   The number of seclusions and restraints reported should be consistent with the number of Level I facility S & R reports received by the T/RBHA. ADHS/DBHS may conduct periodic data validation activities to monitor for data quality and completeness.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
MORTALITY REVIEW FORM: Children, SMI-Enrolled Recipients and Non-SMI Enrolled Recipients

ADHS DOCKET# _____ **DBHS OFFICE USE ONLY**

T/RBHA: _____ _____

Date of Report: _____ **Date of Death:** _____

I. CLIENT INFORMATION

Client Name: _____

Client ID#: _____ SS #: _____

Date of Birth: _____ Sex: Male _____ Female _____

Select One: Child ___ Adult SMI ____ Adult GMH/SA_____ _____ _____

Select One: TXIX TXXI Non-TXIX/XXI _____ _____

Marital Status: _____ Ethnicity: _____

Last Residence: Private Residence: _____ Alone: _____ W/Family: _____ W/Non Family: _____

Supported Housing: Alone: _____ W/Family: _____ W/Non Family: _____

Supervisory Care: _____ Arizona State Hospital: _____ Behavioral Health Facility: _____

Homeless: _____ Nursing Home/Hospice: _____ Jail: _____

Other (Please describe): _____

Date of Enrollment (Most recent date if multiple enrollment dates):

THE FOLLOWING SECTION DOES NOT REQUIRE COMPLETION IF THE REPORTED DEATH OF A NON-SMI BEHAVIORAL HEALTH RECIPIENT IS DUE TO A NATURAL CAUSE

TO COMPLETE THE FOLLOWING SECTIONS, THE ASSESSOR MUST REVIEW THE LAST 12 MONTHS OF THE MEDICAL RECORD

II. DEATH INFORMATION

Has the cause of death been determined? Yes _____ No _____

If no, please specify the date when autopsy will be completed: _____

If yes, please complete the following information:

Reported cause of death: _____

Did client commit suicide? Yes _____ No _____ Cannot Determine _____

Location of death: _____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Last Revision: 06/05/2006
Effective: 10/01/2006

Did the person have a history of suicide attempts? ☐ Yes ☐ No
If yes, describe any strategies used by the behavioral health practitioner or clinical team to prevent future attempts (attach a copy of the relevant documentation):

_____
_____
_____

Describe circumstances concerning the client's death up to 4 weeks previous, if relevant. Include statements made by client, family, witnesses, how you learned about the client's death, emergency interventions/services provided, and client's response to these services. (Must include substance abuse, significant loss, medical problems, and recent release from jail within the last 12 months, etc.).

_____
_____
_____
_____
_____
_____

Current Course of Treatment & Brief History:
Outline in chronological order the clinical course of behavioral health treatment over the past three (3) months (include information about client participation, intensity of case management and services, hospitalization, response to treatment, medication non-compliance, etc.).

Date	Service	Summary of Encounter/Participation/Outcome/ Mental Health Status

III. PSYCHIATRIC & PSYCHOSOCIAL INFORMATION

Psychiatrist/Prescriber (Name): _____

Date of last contact with Psychiatrist/Prescriber: _____

How long has this Psychiatrist/Prescriber been working with this consumer?_____

Date of last contact with Nurse: _____

Clinical Liaison (Name and Phone #): _____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Date of last contact with Clinical Liaison: _____

How long has this Clinical Liaison been working with this consumer: _____

Most Recent Psychiatric Dx: Axis I- Codes: _____

Axis II- Code: _____

Most Recent Medical Dx: Axis III Codes: _____

Current Medications (Psychiatric and Non-Psychiatric) – Type & Dosage:

_____
_____
_____

IV. MEDICAL INFORMATION

Primary Care Physician (Name): _____

Brief description of physical health one (1) year prior to death (include information about history of pain management treatment, frequent Emergency Department visits, and other specific issues that would impact health and the need to coordinate care with the Primary Care Physician):

_____
_____
_____

V. Reason Why Addendum Required:

☐ Suicide ☐ Homicide ☐ Drug overdose (prescribed or illicit)

☐ Accident ☐ Unexpected or unusual medical causes ☐ Request of ADHS/DBHS

☐ Not Applicable

VI. Was Corrective Action Taken? ☐ Yes ☐ No

If yes, please describe.

_____
_____
_____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Last Revision: 06/05/2006
Effective: 10/01/2006

MORTALITY REVIEW ADDENDUM

1. Did the person have family members involved with his or her behavioral health care? □ Yes □ No
   If yes:
   a. Describe what information was obtained from family members/guardian in terms of history of symptoms and treatment; early signs of decompensation; typical course of decompensation:

   _____

   _____

   _____

   b. Describe what information obtained from family members/guardian was incorporated in the treatment approach used by the behavioral health practitioner or clinical team:

   _____

   _____

   _____

   c. Describe what information/education was provided to family members/guardian with the enrolled person's consent or to the extent allowed by state law:

   _____

   _____

   _____

2. Did the person have co-occurring substance abuse issues? □ Yes □ No

   If yes, describe the treatment services that were offered/received that specifically addressed the substance abuse and the outcomes of such treatment:

   _____

   _____

   _____

   _____

3. Was the person adhering to treatment recommendations (taking medication as prescribed, attending appointments, etc.)? □ Yes □ No

   If no, please explain, including engagement and outreach efforts, clinical team communication/decision making, and if petition/amendment was considered when appropriate:

   _____

   _____

   _____

   _____

   If yes, describe what steps were taken to ensure the person received needed treatment. Were there any identified unmet needs?

   _____

   _____

   _____

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

4. Did the person experience troublesome symptoms or side effects of medication that interfered with his or her ability to function? □ Yes □ No

   If yes, describe what steps were taken to improve the person's status or overall ability to function:

   _____

   _____

   _____

5. Had the person been discharged from an inpatient or residential setting within 30 days prior to the death? □ Yes □ No

   If yes, describe what steps were taken to ensure that coordinated discharge planning with the clinical team occurred and the person's needs were adequately met in the lower level of care:

   _____

   _____

   _____

6. SMI Behavioral Health Recipients: Did the person have co-occurring medical conditions, requiring medical care? □ Yes □ No

   a. If yes, describe actions taken by the behavioral health practitioner or clinical team to coordinate medical care:

   _____

   _____

   _____

   b. If no medical practitioner, describe actions taken by the behavioral health practitioner or clinical team to obtain needed medical care:

   _____

   _____

   _____

7. Is the cause of death still under review? □ Yes □ No

   If yes, please specify the date when investigation will be completed: _____

Name & Title of Person Preparing Report:

Signature Title Date

Name and Title of T/RBHA Person completing clinical/medical review, when indicated:

Signature Title Date

T/RBHA Medical Director or Designee:

_____

Signature Date

All information regarding this case is confidential under 42 CFR 438.240, A.R.S. 36-445, A.R.S. 36-2401 et. seq., and A.R.S. 36-2917

Last Revision: 06/05/2006
Effective: 10/01/2006

CHILDREN'S SYSTEM OF CARE STRUCTURAL ELEMENTS

DESCRIPTION

The Structural Elements are a series of quality management reports that are utilized to measure growth within the children's behavioral health system, with the goal to serve all children and their families in accordance with the 12 Arizona Principles. The data is submitted monthly by the T/RBHAs and a rolling 6-month report is available electronically on the ADHS/DBHS Common drive. The reports are also accessible on the ADHS/DBHS website, covering a 12-month period in quarterly intervals, to compare change over time.

METHODOLOGY

Population
All Title XIX/XXI children and young adults under the age of twenty-one (21).

Reporting Frequency
Monthly.

Data Source
T/RBHA-submitted Children's System Structural Elements data.
ADHS/DBHS Enrollment Penetration Report (http://www.azdhs.gov/bhs/enroll_pen.htm.)

Data Collection Timeline and Delivery
T/RBHA reports are submitted via e-mail to the ADHS/DBHS Quality Management Department by the 15th day following the end of each reporting month. Monthly data is a snapshot of activity as of the final day of the reporting month.

Data Reporting
Refer to Attachment A for data elements included in T/RBHA reports.

The Structural Elements reports published by ADHS/DBHS Quality Management Department include:

- Percent of T/RBHA-enrolled children with Functioning Child and Family teams
- Percent of T/RBHA-enrolled children placed out of home
- Number and percentage of enrolled children in out of home placements by type of placement (Level 1,2,3)
- Number and percentage of enrolled children placed out-of-state
- Percent of T/RBHA-enrolled children who are receiving Home Care Training services.

QUALITY CONTROL

Significant fluctuations in numbers reported each month are verbally checked with the T/RBHA.

CONFIDENTIALITY PLAN

Data is presented in aggregate form. Reports do not contain individual identifying information.

CHILDREN'S SYSTEM STRUCTURAL ELEMENTS

1. **Child and Family Teams** - point in time as of final day of the reporting period:												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
a. # of personnel trained by RBHA and currently available to facilitate CFT process												
b. # of currently functioning CFTs*												

2. **Use of Out-of-Home Services** - point in time as of final day of the month:												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
a. # of children in out-of-state placements												
b. # of children in Level I placements (Total)												
● Inpatient hospitalization/Subacute facility												
● Level I Residential Treatment Center												
c. # of children in Level II placements												
d. # of children in Level III placements												
e. # of children in HCT services												

3. **Urgent Behavioral Health Response for Children Entering Foster Care**- submit RBHA totals covering all days in the calendar month, broken down as follows:												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
a. # of referrals for Urgent BH Response for Children Entering Foster Care												
b. # of children in 3a. above who were already enrolled with RBHA prior to this referral												
c. # of children in 3a. above who are below age 5 ("birth thru four") at time of this referral												
d. # of Urgent BH Responses for Children Entering FC completed this month												

Definitions:

FUNCTIONING Child and Family Team : a.) is facilitated by a trained person; b.) the CFT has met at least one time and, since then, has continued to function in accordance with ADHS technical assistance document #3, The Child and Family Teams Process;

Level 1 psychiatric acute hospital means an inpatient treatment program that provides continuous treatment to an individual who is experiencing a behavioral health issue that causes the individual: To be a danger to self, a danger to others, or gravely disabled; or to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or the capacity to recognize reality. Level 1 sub-acute agency means an inpatient treatment program that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual: to have a limited or reduced ability to meet the individual's basic physical and age-appropriate needs; to be a danger to self, a danger to others, or gravely disabled; or to suffer severe and abnormal mental, emotional, or physical harm that impairs judgment, reason, behavior, or the capacity to recognize reality.

Level I RTC : Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms.

Note: In some regions individuals other than behavioral health representatives (e.g., family members, CPS workers, community volunteers) have been trained by the RBHA to facilitate the CFT process. The "trained person" need not necessarily be an employee of the behavioral health system for the purpose of counting "functioning CFTs".

RBHA data will be submitted directly to Tilmon Broadway (broadwt@azdhs.gov), ADHS Quality Management Operations, by the 15th day following the end of each reporting month. Reported data will be compiled monthly and shared publicly (e.g., ADHS website).

PHARMACY REPORT

METHODOLOGY

Population
Title XIX/XXI children and adults receiving behavioral health services through the RBHA.

Reporting Frequency
Quarterly.

Data Source
RBHA pharmacy data.

Data Reporting
Data is reported via Excel spreadsheets submitted to the Office of Medical Management 45 days post-quarter. Data must be reported per Attachment A.

QUALITY CONTROL

RBHAs are responsible for establishing quality controls to ensure data is accurate and complete. ADHS reviews data for notable trends or possible discrepancies and sends to the RBHA for correction.

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level.

Arizona Department of Health Service

FY06, 3rd Quarter
Jan 1 - March 31, 2006

RBHA Pharmacy Data

RBHA	Total Member Months	Pharmacy Count	Number Prescriptions PMPM	Cost PMPM	Average Cost Generic	Average % generic prescriptions	Total Ingredient Cost	Average Ingredient Cost	Total Dispensing Fee	Total Amount Paid	Total Cost per Prescription	Average Cost Multi-source prescription	Average cost single source prescription

SUBSTANCE USE DISORDER AND CO-OCCURRING DISORDERS

DESCRIPTION

Purpose:
To maintain a consistent method of defining the population of behavioral health recipients with substance use and co-occurring substance use/mental health disorders. This protocol applies to the following:

1. Annual Report on Substance Abuse Treatment (ARS 36-2023)
2. Substance Abuse Performance Partnership Block Grant
3. Community Mental Health Services Block Grant
4. Master List Performance Measures
5. Ad hoc reporting

METHODOLOGY

Definitions:
Persons with Substance Use Disorder
Behavioral health recipients for whom substance use is identified.

Co-Occurring Disorder
Behavioral health recipients for whom both substance use and a co-existing mental health disorder is identified.

Procedures:
Persons with Substance Use Disorder

1. Any record with an Axis 1 (fields Axis 1.1 through Axis 1.5) substance use diagnosis (where the 1st 3 digits of the DSM IV code is 291, 292, 303, 304, or 305, excluding tobacco related codes such as 305.1 and 305.10) OR
2. Any record with a Behavioral Health Category: Substance Abuse (Value = "G") OR
3. Any record with a primary or secondary or tertiary substance problem type that is not equal to "none" (Value = "0001") or is not blank.
   a. For 0201 Alcohol, exclude SA Freq. of 1 (no use), 2 (1-3 times in past month), and 3 (1-2 times per week)
4. Identification of behavioral health recipients as Substance Abuse may also be completed by combining the proceeding criteria and providing an unduplicated count.

Co-Occurring Disorders

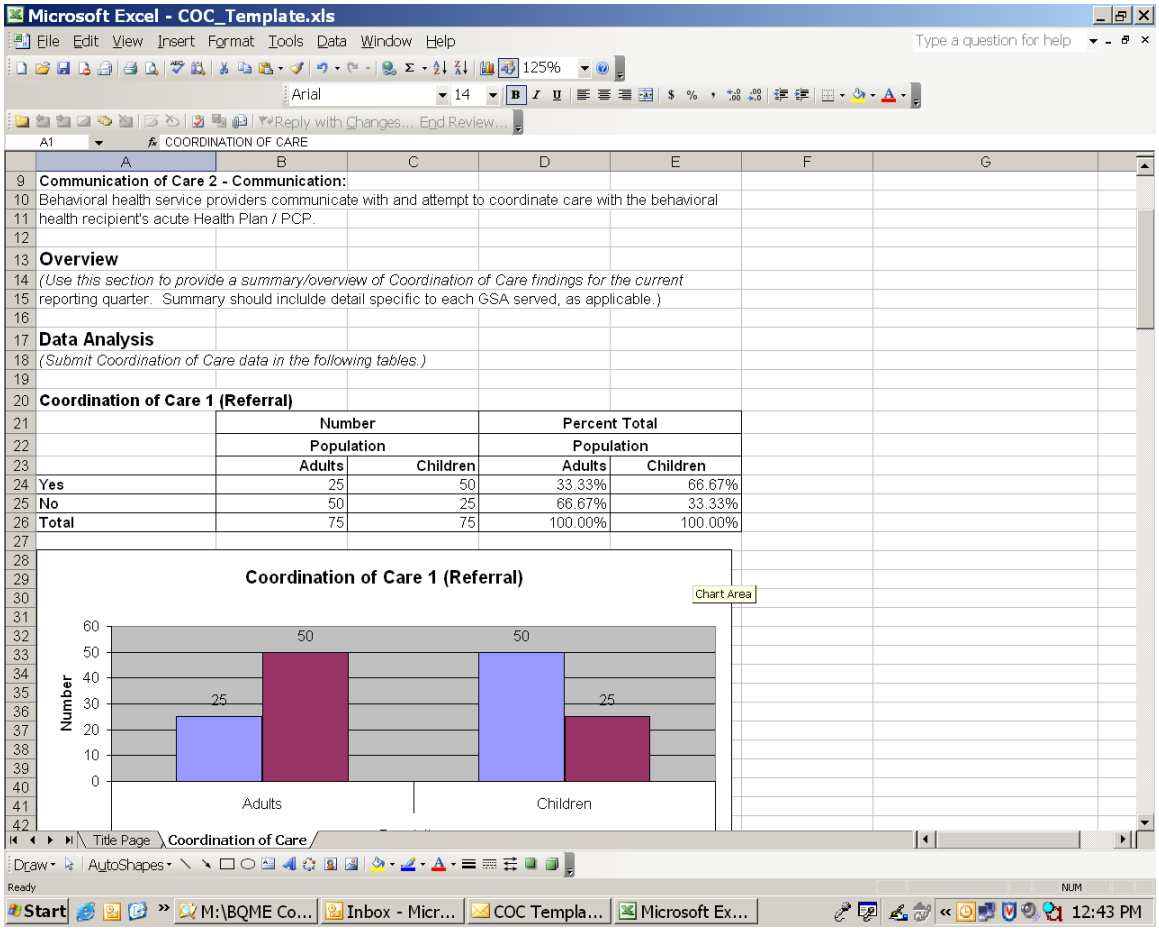
1. Establish unduplicated records with a substance use disorder (as above)

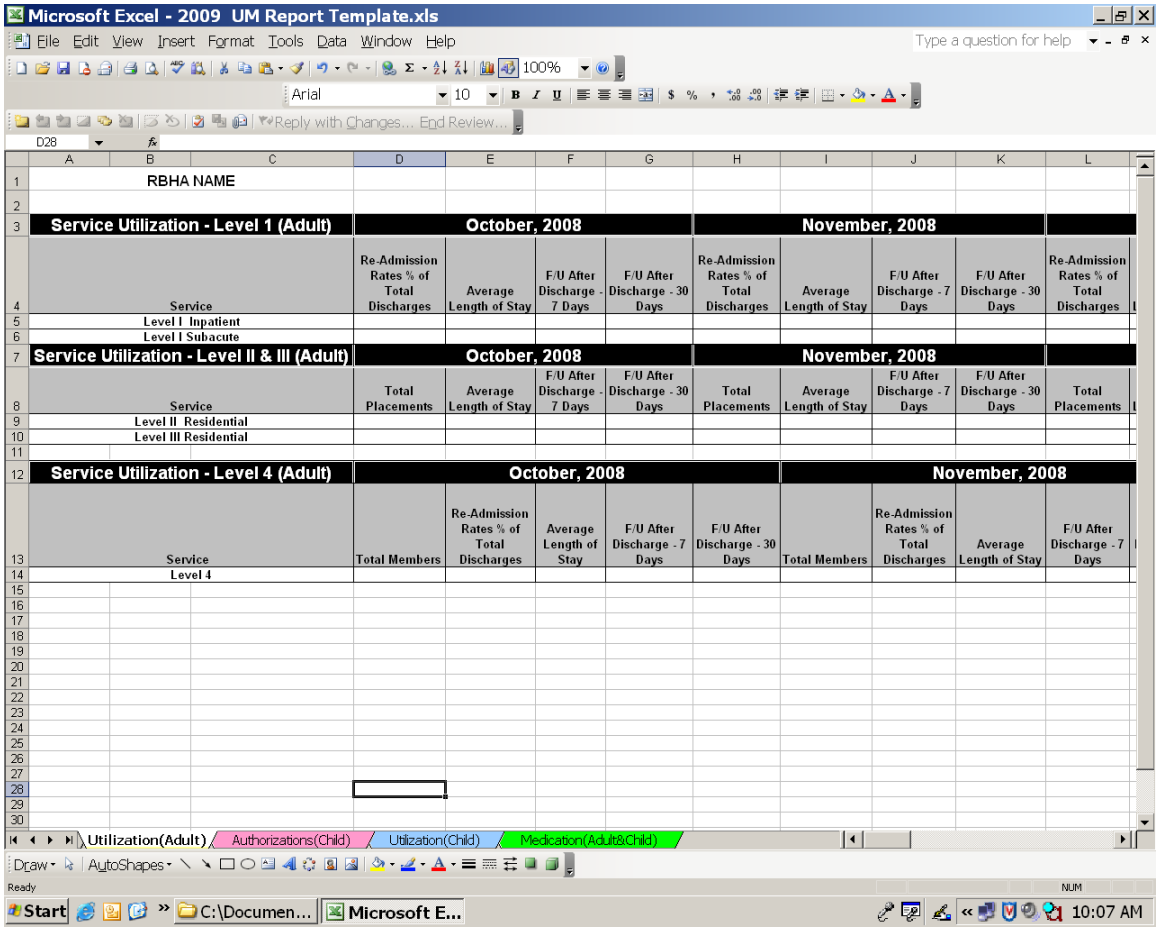
2. Stratify group by records with substance use disorder only (single diagnosis procedure) and records with substance use disorders and one or more mental health disorders (mental health disorder DSM IV codes in fields Axis 1.2 through Axis 1.5 or Axis 2.1 through 2.2).
3. Stratify both groups by Adult and Child.
4. Stratify Adult by SMI Adult, Non-SMI Adult

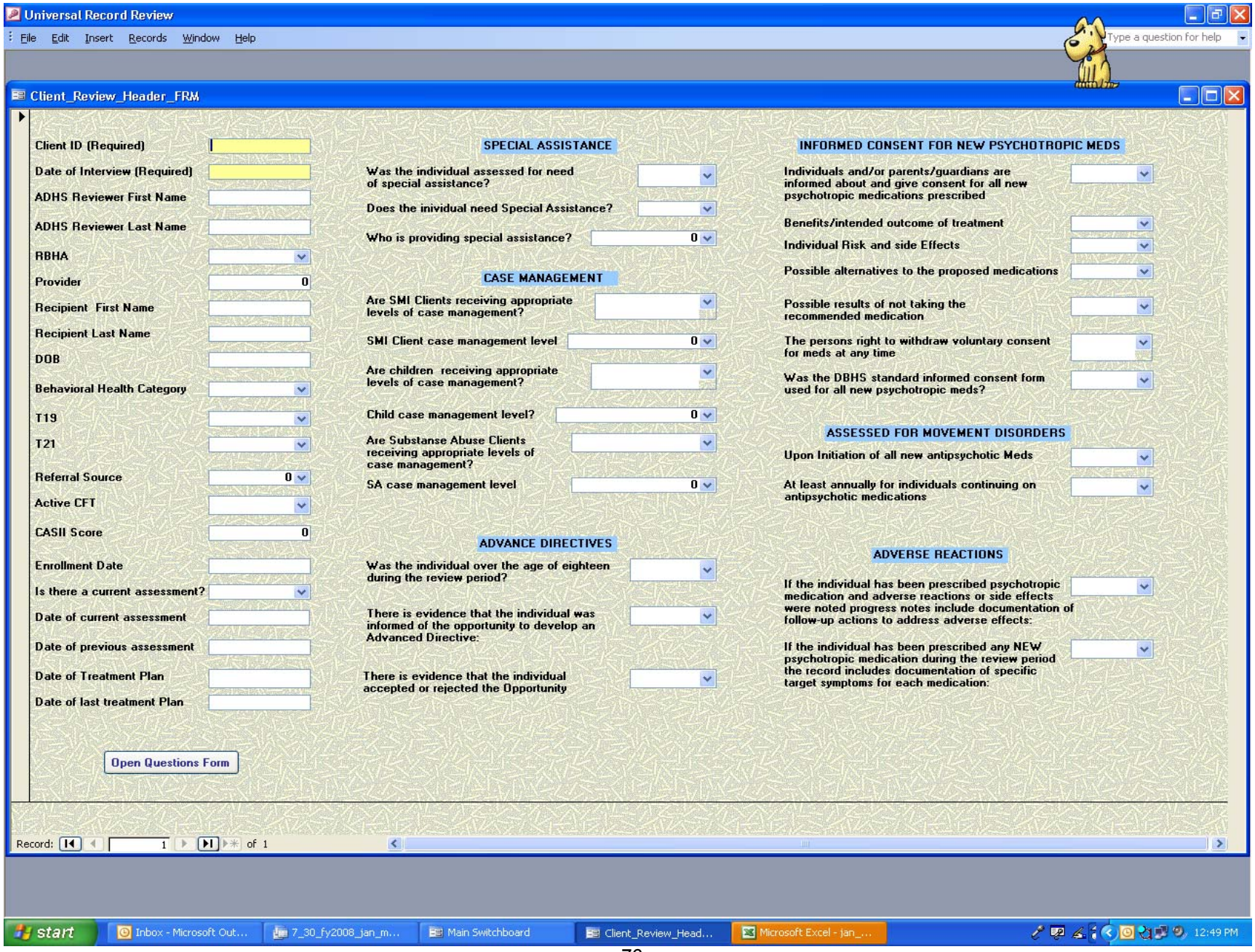
Data Source
Client Information System (CIS) Client Demog table

CONFIDENTIALITY PLAN

All data accessed for calculation of this performance measure is confidential and HIPAA-compliant. All data is aggregated at the RBHA level only and is not presented at an individual level. Data collected for the substance use disorder and co-occurring disorders measure is used only for this project.


Microsoft Excel - COC_Template.xls
File Edit View Insert Format Tools Data Window Help
Type a question for help
Arial 14
Reply with Changes... End Review...
A1 COORDINATION OF CARE
Communication of Care 2 - Communication:
Behavioral health service providers communicate with and attempt to coordinate care with the behavioral health recipient's acute Health Plan / PCP.
Overview
(Use this section to provide a summary/overview of Coordination of Care findings for the current reporting quarter. Summary should includle detail specific to each GSA served, as applicable.)
Data Analysis
(Submit Coordination of Care data in the following tables.)
Coordination of Care 1 (Referral)
Number
Percent Total
Population
Adults
Children
Yes 25 50 33.33% 66.67%
No 50 25 66.67% 33.33%
Total 75 75 100.00% 100.00%
Coordination of Care 1 (Referral)
Chart Area
Number
60
50
40
30
20
10
0
25
50
50
25
Adults
Children
Title Page
Coordination of Care
Draw
AutoShapes
Ready
NUM
Start
M:\BQME Co...
Inbox - Micr...
COC Templa...
Microsoft Ex...
12:43 PM

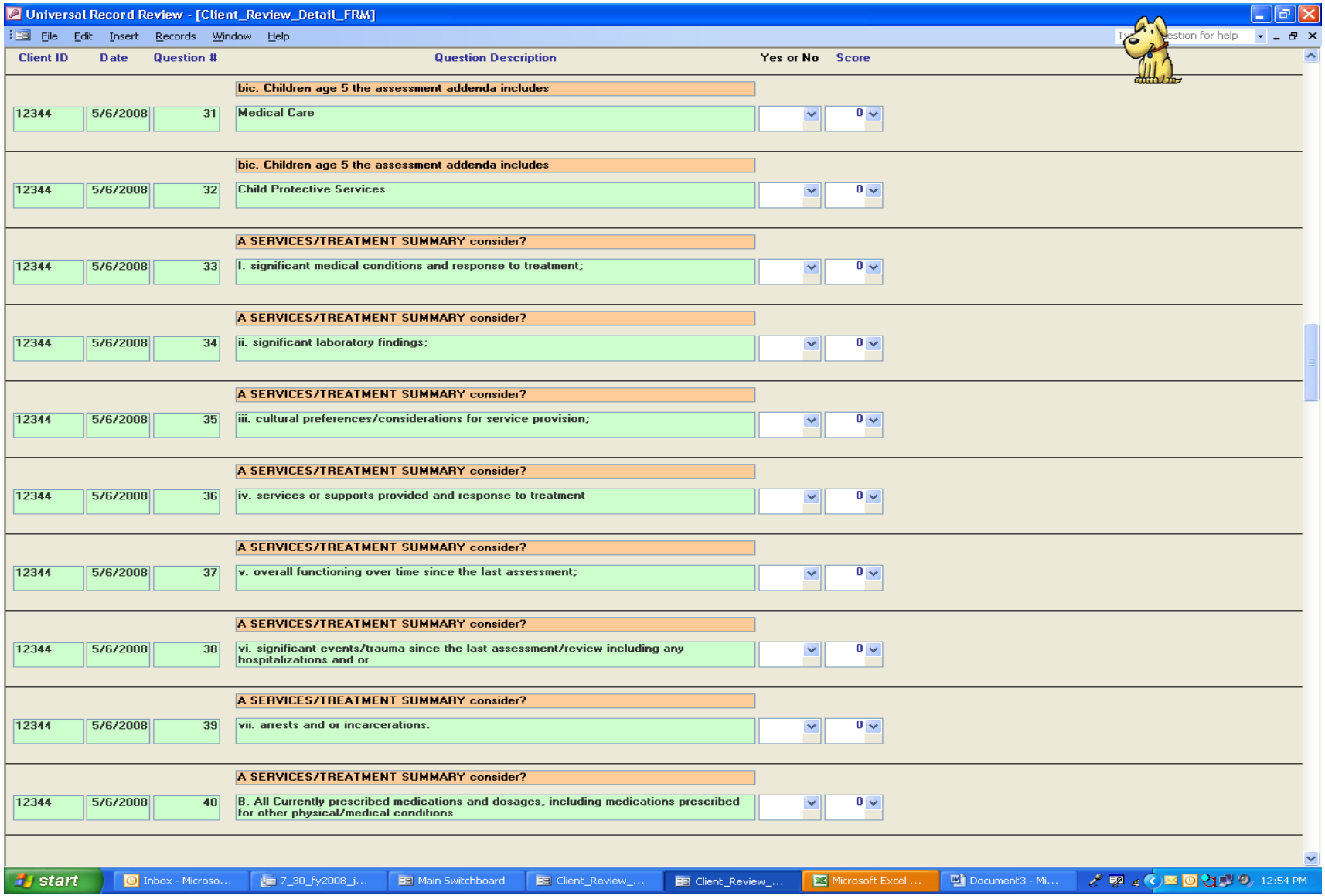

Microsoft Excel - 2009 UM Report Template.xls
File Edit View Insert Format Tools Data Window Help
Type a question for help
Arial 10
Reply with Changes... End Review...
D28
RBHA NAME
Service Utilization - Level 1 (Adult)
October, 2008
November, 2008
Service
Re-Admission Rates % of Total Discharges
Average Length of Stay
F/U After Discharge - 7 Days
F/U After Discharge - 30 Days
Level I Inpatient
Level I Subacute
Service Utilization - Level II & III (Adult)
Total Placements
Level II Residential
Level III Residential
Service Utilization - Level 4 (Adult)
Total Members
Level 4
Utilization(Adult)
Authorizations(Child)
Utilization(Child)
Medication(Adult&Child)
Draw AutoShapes
Ready
NUM
Start
C:\Documen...
Microsoft E...
10:07 AM


Universal Record Review
File Edit Insert Records Window Help
Type a question for help
Client_Review_Header_FRM
Client ID (Required)
Date of Interview (Required)
ADHS Reviewer First Name
ADHS Reviewer Last Name
RBHA
Provider
Recipient First Name
Recipient Last Name
DOB
Behavioral Health Category
T19
T21
Referral Source
Active CFT
CASII Score
Enrollment Date
Is there a current assessment?
Date of current assessment
Date of previous assessment
Date of Treatment Plan
Date of last treatment Plan
Open Questions Form
SPECIAL ASSISTANCE
Was the individual assessed for need of special assistance?
Does the inividual need Special Assistance?
Who is providing special assistance?
CASE MANAGEMENT
Are SMI Clients receiving appropriate levels of case management?
SMI Client case management level
Are children receiving appropriate levels of case management?
Child case management level?
Are Substanse Abuse Clients receiving appropriate levels of case management?
SA case management level
ADVANCE DIRECTIVES
Was the individual over the age of eighteen during the review period?
There is evidence that the individual was informed of the opportunity to develop an Advanced Directive:
There is evidence that the individual accepted or rejected the Opportunity
INFORMED CONSENT FOR NEW PSYCHOTROPIC MEDS
Individuals and/or parents/guardians are informed about and give consent for all new psychotropic medications prescribed
Benefits/intended outcome of treatment
Individual Risk and side Effects
Possible alternatives to the proposed medications
Possible results of not taking the recommended medication
The persons right to withdraw voluntary consent for meds at any time
Was the DBHS standard informed consent form used for all new psychotropic meds?
ASSESSED FOR MOVEMENT DISORDERS
Upon Initiation of all new antipsychotic Meds
At least annually for individuals continuing on antipsychotic medications
ADVERSE REACTIONS
If the individual has been prescribed psychotropic medication and adverse reactions or side effects were noted progress notes include documentation of follow-up actions to address adverse effects:
If the individual has been prescribed any NEW psychotropic medication during the review period the record includes documentation of specific target symptoms for each medication:
Record: 1 of 1
start
Inbox - Microsoft Out...
7_30_fy2008_jan_m...
Main Switchboard
Client_Review_Head...
Microsoft Excel - jan_...
12:49 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
ASSESSMENT - Initial Documentation
12344 | 5/6/2008 | 1 | a. Is there an initial assessment or annual update? | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 2 | Presenting Concerns | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 3 | The Medical and Behavioral Questionnaire (must be completed or reviewed at initial appointment) | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 4 | Criminal Justice (must be completed at the initial appointment but if indicated as necessary the criminal justice addendum can be completed at a follow-up appointment) | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 5 | Substance Related Disorders (Part A must be completed at initial appointment and Part B and C if indicated as necessary) | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 6 | Abuse/Sexual Risk Behavior (must be completed at initial appointment with some questions only completed if appropriate) | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 7 | Risk Assessment (must be completed at initial appointment with some questions only completed if appropriate) | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 8 | Mental Status Exam | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 9 | Clinical Formulation and Diagnoses | | 0
bi.For children over 5 and adults the core assessment includes
12344 | 5/6/2008 | 10 | Next Steps/Interim Service Plan | | 0
start
Inbox - Microso...
7_30_fy2008_i...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:51 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 11 | Living Environment (for all Behavioral Health Recipients) Family/Community Involvement (for all Behavioral Health Recipients) | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 12 | Educational/Vocational Training (for school age children and adults if appropriate) | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 13 | Employment (for Behavioral Health Recipients 16 years and older or as pertinent) Developmental History (for all children and for adults who have developmental | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 14 | Criminal Justice (for Behavioral Health Recipients with legal system involvement) | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 15 | Problem Gambling Screening (for Behavioral Health Recipients age 16 and older when applicable) | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 16 | SMI determination (for Behavioral Health Recipients who request an SMI determination or who have a qualifying SMI diagnosis and a GAF score that is 50 or lower) | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 17 | Child Protective Services (used for 24 hour urgent responses for children removed by CPS | | 0
bia.For children over age 5 and adults the assessment addenda includes
12344 | 5/6/2008 | 18 | Special Suicide Risk Assessment (for Behavioral Health Recipients in crisis situations and when it is clinically indicated) | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 19 | Reason for assessment | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 20 | Childs Routines/Activities | | 0
start
Inbox - Microso...
7_30_fy2008_j...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:52 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 21 | Developmental Issues | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 22 | Child's Medical History | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 23 | Risk Assessment | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 24 | Family Information | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 25 | Observation of the Family/Child Interactions | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 26 | Clinical Formulations and Diagnoses; | | 0
bib. Children age 5 the core assessment includes
12344 | 5/6/2008 | 27 | Next Steps/Interim Service Plan | | 0
bic. Children age 5 the assessment addenda includes
12344 | 5/6/2008 | 28 | Family Culture and History Addenda | | 0
bic. Children age 5 the assessment addenda includes
12344 | 5/6/2008 | 29 | Developmental Checklist or Ages and Stages Questionnaire | | 0
bic. Children age 5 the assessment addenda includes
12344 | 5/6/2008 | 30 | Behavioral Analysis | | 0
start
Inbox - Microso...
7_30_fy2008_i...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:53 PM

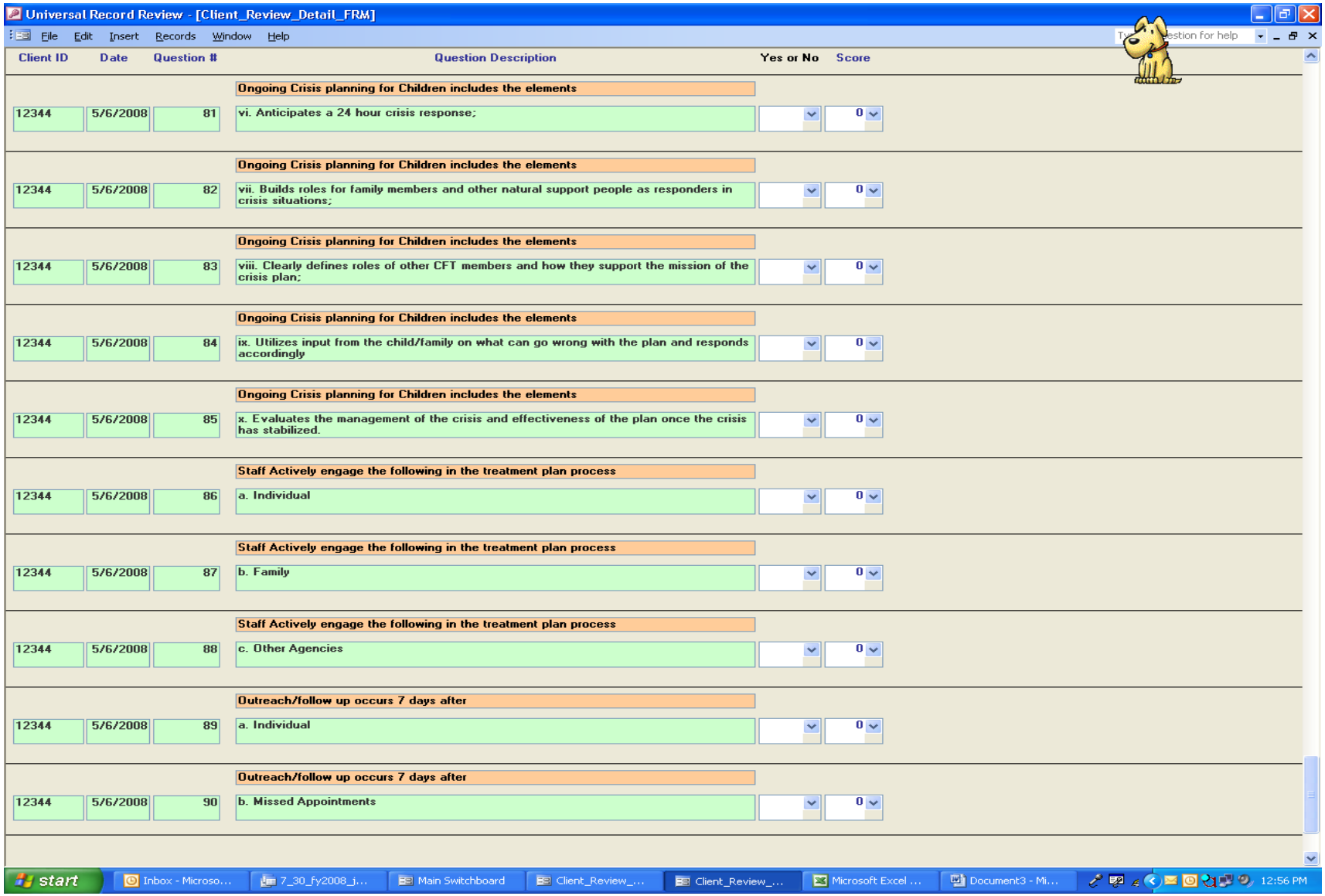

Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
bic. Children age 5 the assessment addenda includes
12344 | 5/6/2008 | 31 | Medical Care | | 0
bic. Children age 5 the assessment addenda includes
12344 | 5/6/2008 | 32 | Child Protective Services | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 33 | I. significant medical conditions and response to treatment; | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 34 | ii. significant laboratory findings; | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 35 | iii. cultural preferences/considerations for service provision; | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 36 | iv. services or supports provided and response to treatment | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 37 | v. overall functioning over time since the last assessment; | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 38 | vi. significant events/trauma since the last assessment/review including any hospitalizations and or | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 39 | vii. arrests and or incarcerations. | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 40 | B. All Currently prescribed medications and dosages, including medications prescribed for other physical/medical conditions | | 0
start
Inbox - Microso...
7_30_fy2008_j...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:54 PM

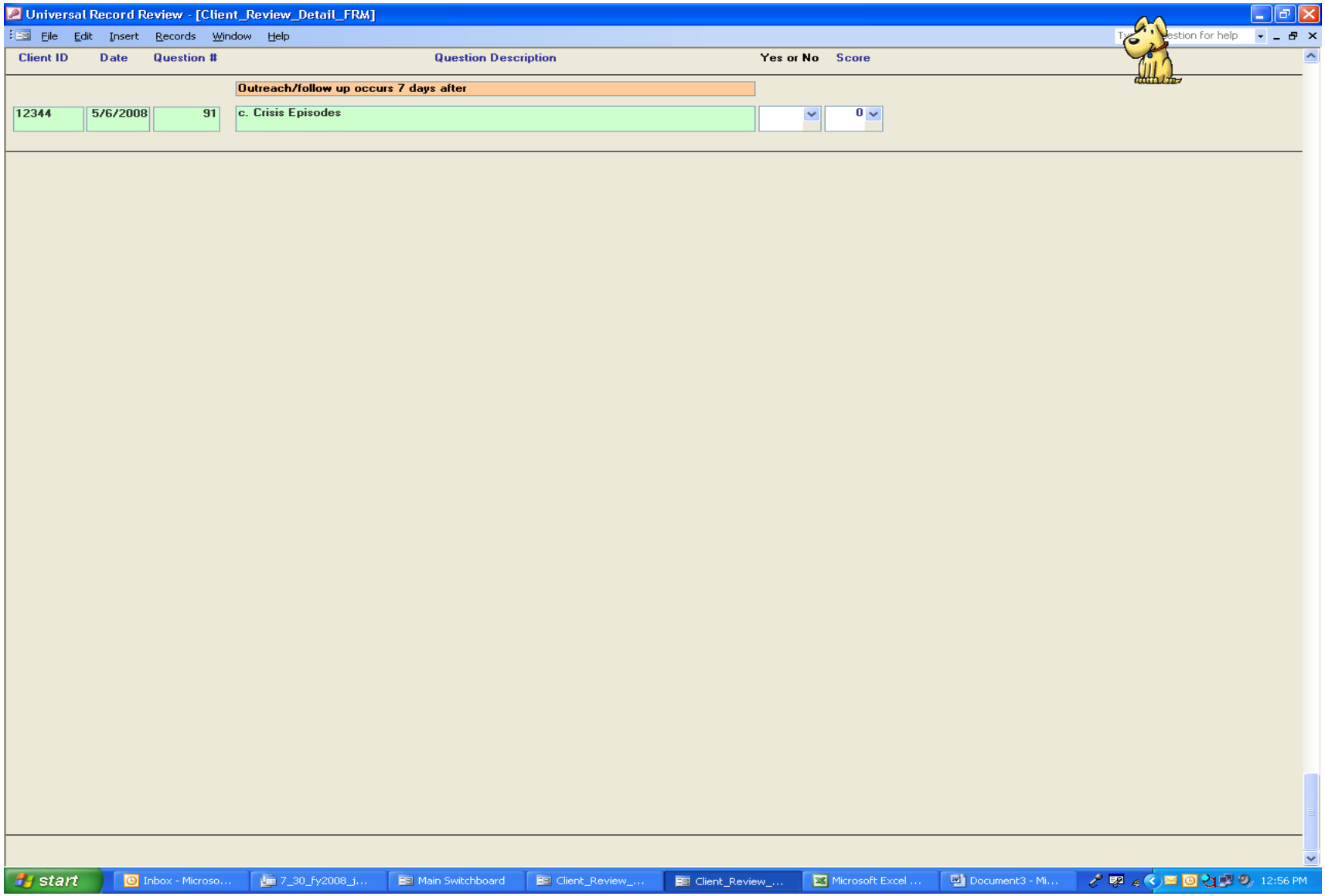

Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 41 | C.A. describe person's current overall functioning and progress in reaching treatment objectives: | | 0
A SERVICES/TREATMENT SUMMARY consider?
12344 | 5/6/2008 | 42 | D description of any significant long-term chronic risk factors | | 0
Does the CURRENT DIAGNOSTIC SUMMARY include
12344 | 5/6/2008 | 43 | 1. Axis I. DSM-IV TR Code Diagnosis Justification for diagnoses (es) | | 0
Does the CURRENT DIAGNOSTIC SUMMARY include
12344 | 5/6/2008 | 44 | 2. Axis II. DSM-IV TR Code Diagnosis Justification for diagnosis (es) | | 0
Does the CURRENT DIAGNOSTIC SUMMARY include
12344 | 5/6/2008 | 45 | 3. Axis III. The person's specific medical conditions | | 0
Does the CURRENT DIAGNOSTIC SUMMARY include
12344 | 5/6/2008 | 46 | 4. Axis IV. (Psychosocial or Environmental Stressors) | | 0
Does the CURRENT DIAGNOSTIC SUMMARY include
12344 | 5/6/2008 | 47 | 5. Axis V. (GAF or CGAS score) | | 0
Do RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT inclu
12344 | 5/6/2008 | 48 | 1. List all prior goals that have not been achieved that still need to remain a focus of services/treatment | | 0
Do RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT inclu
12344 | 5/6/2008 | 49 | 2. List any new goals for the service plan | | 0
Do RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT inclu
12344 | 5/6/2008 | 50 | 3. List other ongoing needs or concerns that need to be addressed including coordination of care with PCP | | 0
start
Inbox - Microso...
7_30_fy2008_j...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:54 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
Do RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT inclu
12344 | 5/6/2008 | 51 | 4. Identify any areas in the assessment that need to be reassessed due to significant changes e.g. person's condition/living environment/support structure | | 0
Do RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT inclu
12344 | 5/6/2008 | 52 | Signature and credentials of person completing the assessment | | 0
Do RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT inclu
12344 | 5/6/2008 | 53 | Date of the assessment occurred | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 54 | Has a recovery goal/person family vision | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 55 | List the person strength | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 56 | The plan is based on the current assessment | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 57 | The types and intensity of services are based on the needs of the individual | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 58 | Has specific objectives to address the identified needs of the individual | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 59 | Objectives are measurable | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 60 | List the specific services and frequency of services to be provided to achieve the objective | | 0
start
Inbox - Microso...
7_30_fy2008_j...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:54 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 61 | Signature of the individual/guardian | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 62 | Indication the individual agreed or disagreed with the plan | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 63 | Signature of responsible provider staff | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 64 | For individuals diagnosed with co-occurring psychiatric illness and substance abuse the treatment plan and/or progress notes includes therapy for both the psychiatric and | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 65 | If diagnosed solely with a substance abuse/dependence disorder the treatment plan and/or progress notes includes appropriate therapy and supports based on the | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 66 | For individuals diagnosed with co-occurring psychiatric illness and substance abuse or solely with a substance abuse/dependence progress notes and interventions | | 0
Treatment Plans for Adults address the elements
12344 | 5/6/2008 | 67 | Treatment plans were revised based on progress or lack of progress of the individuals overall condition | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 68 | I. reflect the family's prioritization of needs and goals; | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 69 | ii. incorporate pertinent identified strengths and cultural considerations within its strategies to achieve successful outcomes; | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 70 | iii. be individualized and responsive to the child and family's needs; | | 0
start
Inbox - Microso...
7_30_fy2008_i...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:55 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 71 | iv. assign responsibility to CFT members for each strategy/intervention/task and establish timelines for implementation; | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 72 | v. utilize both formal and informal/natural supports and services as indicated; | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 73 | vi. identify natural supports and connections to community supports which may need to be developed or re-energized; | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 74 | vi. identify outcomes actions and strategies/interventions/tasks related to the family's vision for the future | | 0
Treatment Plans for Children address the elements
12344 | 5/6/2008 | 75 | vii. include measures by which the child/family and CFT can monitor progress. | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 76 | I. Anticipates crises based on knowledge of past behavior as an indicator of future behavior; | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 77 | ii. Researches past crises to identify for each situation the preceding behaviors impulsive behavioral responses (thought and action) and the consequent behaviors | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 78 | iii. Changes over time in response to what is known to be effective or ineffective interventions; | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 79 | iv. Contains clear behavioral benchmarks that change over time to reflect progress changing capacities and changes in the child/family's expectations; | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 80 | v. Triages the intensity of response actions to align with the severity level of the crisis situation; | | 0
start
Inbox - Microso...
7_30_fy2008_j...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:55 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID | Date | Question # | Question Description | Yes or No | Score
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 81 | vi. Anticipates a 24 hour crisis response; | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 82 | vii. Builds roles for family members and other natural support people as responders in crisis situations; | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 83 | viii. Clearly defines roles of other CFT members and how they support the mission of the crisis plan; | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 84 | ix. Utilizes input from the child/family on what can go wrong with the plan and responds accordingly | | 0
Ongoing Crisis planning for Children includes the elements
12344 | 5/6/2008 | 85 | x. Evaluates the management of the crisis and effectiveness of the plan once the crisis has stabilized. | | 0
Staff Actively engage the following in the treatment plan process
12344 | 5/6/2008 | 86 | a. Individual | | 0
Staff Actively engage the following in the treatment plan process
12344 | 5/6/2008 | 87 | b. Family | | 0
Staff Actively engage the following in the treatment plan process
12344 | 5/6/2008 | 88 | c. Other Agencies | | 0
Outreach/follow up occurs 7 days after
12344 | 5/6/2008 | 89 | a. Individual | | 0
Outreach/follow up occurs 7 days after
12344 | 5/6/2008 | 90 | b. Missed Appointments | | 0
start
Inbox - Microso...
7_30_fy2008_j...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:56 PM


Universal Record Review - [Client_Review_Detail_FRM]
File Edit Insert Records Window Help
Client ID
Date
Question #
Question Description
Yes or No
Score
Outreach/follow up occurs 7 days after
12344
5/6/2008
91
c. Crisis Episodes
0
start
Inbox - Microso...
7_30_fy2008_i...
Main Switchboard
Client_Review_...
Client_Review_...
Microsoft Excel ...
Document3 - Mi...
12:56 PM

Attachment B
Children's Performance Improvement Report
Q109

Summary of Support and Rehabilitation Services Expansion (FY08 and FY09)							
		FY08 Expansion Funding	Approximate FTEs	FY09 Expansion Funding	Approximate FTEs	Total Expansion Funding	Approximate Total FTEs on 6/30/09
NARBHA - GSA 1	CFSS - Mohave	500,000	8				
	CFSS - Yavapai	500,000	8				
	AzCA - Coconino	500,000	8				
	Total Allocated*	1,457,647	24	381,766	6	1,839,413	30
Cenpatico - GSA 2	Arizona Counseling & Treatment Services (ACTS)	500,000	8				
	Community Intervention Associates (CIA)	500,000	8				
	Total Allocated*	296,195	16	138,649	2	434,844	18
CPSA – GSA 3	SEABHS	562,649	8				
	Total Allocated	562,649	8	132,760	2	695,409	10
Cenpatico - GSA 4	AzCA	500,000	8				
	Horizon	500,000	8				
	Superstition Mnt.	500,000	8				
	Total Allocated*	1,262,686	24	220,844	3	1,483,530	27
CSPA – GSA 5	La Frontera	645,173	8				
	- La Paloma	645,174	8				
	Pantano - Intermountain	739,898	9				
	Pantano - AZCA	739,899	9				
	Providence	1,290,347	14				
	- Devereux		2				
	Total Allocated	4,381,964	50	704,990	10	5,086,954	60
Magellan - GSA 6	CFSS	1,500,000	21				
	Youth ETC	1,275,000	18				
	AYFS	750,000	11				
	Touchstone	670,000	10				
	POCN	335,000	10				
	A New Leaf	670,000	5				
	Expended by Value Options	1,059,887					
	Total Allocated	6,259,887	75	1,413,394	20	7,673,281	95
Total Statewide		**14,221,028**	**197**	**2,992,403**	**43**	**17,213,431**	**240**

Attachment C
Children's Performance Improvement Report
Q109

Summary of Case Manager Expansion (FY08 and FY09)						
	Number of Case Managers from the FY07 Base	**Case Managers funded by FY08 CAP Rate increase**	**Case Managers funded by FY09 CAP Rate increase**	**Minimum # of Case Managers as of June 30, 2009**	**Total # of children with a CM based on 1:15 caseload**	**Case Manages as reported on 9/15/08 inventory at 1:20 or lower**
GSA 1	16	24	17	57	855	25.3
GSA 2	9	9	6	24	360	5.5
GSA 3	9	10	6	25	375	14
GSA 4	11	11	9.5	31.5	472.5	6
GSA 5	32	53	30	115	1725	24
GSA 6	70	61	61	192	2880	90.5
Total Expansion	147	168	129.5	444.5	6667.5	165.3
% of enrolled children with a CM at a 1:15 ratio	20.18%	Total Enrolled Children	33,037			

CHILDRENS PERFORMANCE MEASURES
Numbers Used in Calculation of Performance
Quarter 1 FY2009

Access to Care 7 Day

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	147	147	100.0%
CBHS 4	446	438	98.2%
CPSA 3	176	174	98.9%
CPSA 5	904	899	99.4%
Magellan	3,797	3,516	92.6%
NARBHA	846	807	95.4%
Statewide	*6,316*	*5,981*	*94.7%*

Sufficiency of Assessments

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	6,832	6,808	99.6%
CBHS 4	3,450	3,401	98.6%
CPSA 3	3,828	3,792	99.1%
CPSA 5	30,507	30,039	98.5%
Magellan	39,436	37,752	95.7%
NARBHA	15,256	14,695	96.3%
*Statewide**	*99,309*	*96,487*	*97.2%*

Access to Care 23 Day

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	707	685	96.9%
CBHS 4	1,380	1,185	85.9%
CPSA 3	807	741	91.8%
CPSA 5	4,341	3,880	89.4%
Magellan	11,361	9,117	80.2%
NARBHA	2,489	2,101	84.4%
*Statewide**	*21,085*	*17,709*	*84.0%*

Appropriateness of Services

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	15	15	100.0%
CBHS 4	45	42	93.3%
CPSA 3	30	24	80.0%
CPSA 5	33	30	90.9%
Magellan	30	17	56.7%
NARBHA	33	30	90.9%
*Statewide**	*186*	*158*	*84.9%*

Coordination of Care 1

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	3	3	100.0%
CBHS 4	0	0	N/A
CPSA 3	1	1	100.0%
CPSA 5	2	1	50.0%
Magellan	3	2	66.7%
NARBHA	10	7	70.0%
*Statewide**	*19*	*14*	*73.7%*

Coordination of Care 2

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	16	13	81.3%
CBHS 4	23	22	95.7%
CPSA 3	10	3	30.0%
CPSA 5	33	24	72.7%
Magellan	39	25	64.1%
NARBHA	42	32	76.2%
*Statewide**	*163*	*119*	*73.0%*

RBHA/Statewide Child Complaints by Complaint Category, Q109

	Access to Services		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Service		Financial		Information Sharing		Total	
RBHA	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
CBH AZ 2	0	0%	0	0%	0	0%	1	50%	1	50%	0	0%	0	0%	2	1.70%
CBH AZ 4	1	20%	0	0%	3	60%	0	0%	1	20%	0	0%	0	0%	5	4.20%
CPSA 3	3	43%	0	0%	4	57%	0	0%	0	0%	0	0%	0	0%	7	6.00%
CPSA 5	16	26%	1	1.60%	32	52%	5	0.80%	6	1.00%	1	1.60%	0	0%	61	52%
Magellan	13	36%	2	0.60%	5	14%	7	19%	9	25%	0	0%	0	0%	36	31%
NARBHA	1	14%	0	0%	0	0%	0	0%	4	57%	1	14%	1	14%	7	6
Statewide	**34**	**29%**	**3**	**3.00%**	**44**	**37%**	**13**	**11%**	**21**	**18%**	**2**	**1.70%**	**1**	**0.80%**	**118**	**100%**

84% of all Q109 child complaints fell within highlighted categories.

Child Complaints by Covered Service Category, Q109

Covered Service	Access to Services		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Service		Financial		Information Sharing		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Behavioral Health Day Programs	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Crisis Intervention Services	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0.84%
Inpatient Services	1	14%	1	14%	5	71%	0	0%	0	0%	0	0%	0	0%	7	6.00%
Medication Services	5	30%	0	0%	10	56%	2	11%	1	6.00%	0	0%	0	0%	18	15%
Residential Services	0	0%	0	0%	3	75%	1	25%	0	0%	0	0%	0	0%	4	3.30%
Support Services	8	23%	1	3.00%	9	26%	5	14%	11	31%	1	3.00%	0	0%	35	30%
Treatment Services	19	36%	1	2.00%	17	32%	5	9.40%	9	17%	1	2.00%	1	2.00%	53	45%
Rehabilitation Services	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
None Listed	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Total	34	29%	3	3.00%	44	37%	13	11%	21	18%	2	2.00%	1	0.84%	118	100%

Attachment E

Employment

QM AGE GROUP	QM REF2 CODE	Count Of QM REF2	TOTAL QM AGE GROUP	%BY AGE GROUP
Non-SMI	01	70	1397	5%
Non-SMI	02	87	1397	6%
Non-SMI	03	19	1397	1%
Non-SMI	04	55	1397	4%
Non-SMI	20	674	1397	48%
Total	**18-20 (Non-SMI)**	**905**	**1397**	**65%**
SMI	01	11	340	3%
SMI	02	24	340	7%
SMI	03	4	340	1%
SMI	04	19	340	6%
SMI	20	71	340	21%
Total	**18-20 (SMI)**	**129**	**340**	**38%**

Education

QM AGE GROUP	QM REF2 CODE	Count Of Y QM REF2	TOTAL QM AGE GROUP	% OF YES BY AGE GROUP
00 - 04	Y	107	998	11%
05 - 11	Y	6081	6602	92%
12 - 17	Y	7371	7780	95%
18-20 (Non-SMI)	Y	913	1397	65%
18-20 (SMI)	Y	129	340	38%
TOTAL		**14601**	**17117**	**85%**

Residence

QM AGE GROUP	QM REF2	Count Of QM REF2	TOTAL QM AGE GROUP	%BY AGE GROUP
00 - 04	01	7	998	1%
00 - 04	16	483	998	48%
Total	**00-04**	**490**	**998**	**49%**
05 - 11	01	141	6602	2%
05 - 11	16	5560	6602	84%
Total	**05-11**	**5701**	**6602**	**86%**
12 - 17	01	208	7780	3%
12 - 17	16	6256	7780	80%
Total	**12-17**	**6464**	**7780**	**83%**
18-20 (Non-SMI)	01	241	1397	17%
18-20 (Non-SMI)	16	929	1397	66%
Total	**18-20 (Non-SMI)**	**1170**	**1397**	**84%**

18-20 (SMI)	01	126	340	37%
18-20 (SMI)	16	125	340	37%
TOTAL	**18-20 (SMI)**	**251**	**340**	**74%**

Crime and Criminal Justice

	Age Groups			
Indicator	**12 - 17**	**18 - 20 Non-SMI**	**18 - 20 SMI**	**12 - 20**
No Arrests	6,863	1,166	275	**8,304**
Improve	202	26	18	**246**
Decline	306	86	21	**413**
Same	409	119	26	**554**
Total	**917**	**231**	**65**	**1,213**
Enrolled	**21,246**	**6,357**	**746**	**27,603**

Morbidity

	Age Groups				
Indicator	**5 - 11**	**12 - 17**	**18 - 20 Non-SMI**	**18 - 20 SMI**	**5 - 20**
No Substance Used	6,592	6,809	955	237	**14,593**
Improve	3	113	52	19	**187**
Decline	2	189	51	9	**251**
Same	5	669	339	75	**1,088**
Total	**10**	**971**	**442**	**103**	**1,526**
Enrolled	**19,643**	**21,246**	**6,357**	**746**	**47,246**

ADULT PERFORMANCE MEASURES
Numbers Used in Calculation of Performance
Quarter 1 FY2009

Access to Care 7 Day

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	337	335	99.4%
CBHS 4	850	831	97.8%
CPSA 3	359	351	97.8%
CPSA 5	1,415	1,410	99.6%
Magellan	7,160	6,220	86.9%
NARBHA	1,834	1,758	95.9%
Statewide	*11,955*	*10,905*	*91.2%*

Access to Care 23 Day

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	1,359	1,271	93.5%
CBHS 4	2,475	2,179	88.0%
CPSA 3	1,683	1,498	89.0%
CPSA 5	5,032	4,241	84.3%
Magellan	14,762	13,328	90.3%
NARBHA	5,564	4,814	86.5%
*Statewide**	*16,113*	*14,003*	*86.9%*

*Excludes Magellan

Coordination of Care 1

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	6	6	100.0%
CBHS 4	4	2	50.0%
CPSA 3	2	2	100.0%
CPSA 5	17	8	47.1%
Magellan	83	49	59.0%
NARBHA	21	17	81.0%
*Statewide**	*133*	*84*	*63.2%*

Coordination of Care 2

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	53	43	81.1%
CBHS 4	57	43	75.4%
CPSA 3	55	27	49.1%
CPSA 5	66	48	72.7%
Magellan	66	31	47.0%
NARBHA	64	55	85.9%
*Statewide**	*361*	*247*	*68.4%*

Sufficiency of Assessments

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	6,832	6,808	99.6%
CBHS 4	3,450	3,401	98.6%
CPSA 3	3,828	3,792	99.1%
CPSA 5	30,507	30,039	98.5%
Magellan	39,436	37,752	95.7%
NARBHA	15,256	14,695	96.3%
*Statewide**	*99,309*	*96,487*	*97.2%*

Appropriateness of Services

RBHA	Denominator	Numerator	% in Compliance
CBHS 2	114	63	55.3%
CBHS 4	123	103	83.7%
CPSA 3	117	87	74.4%
CPSA 5	126	85	67.5%
Magellan	120	70	58.3%
NARBHA	120	84	70.0%
*Statewide**	*720*	*492*	*68.3%*

Complaint Rate per Thousand

RBHA	Enrollment	# Complaints	Rate per 1,000
CBHS 2	2,975	3	1.0
CBHS 4	4,599	15	3.3
CPSA 3	3,196	14	4.4
CPSA 5	14,800	649	43.9
Magellan	35,732	319	8.9
NARBHA	9,300	65	7.0
*Statewide**	70,602	1,065	15.1

RBHA/Statewide Adult Complaints by Complaint Category Q109

	Access to Service		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Services		Financial		Information Sharing		Total	
RBHA	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
CBH 2	2	66%	0	0%	0	0%	0	0%	0	0%	1	33%	0	0%	3	0.02%
CBH 4	6	40%	3	20%	0	0%	2	13%	2	13%	2	13%	0	0%	15	1.40%
CPSA 3	3	21%	0	0%	6	43%	0	0%	5	36%	0	0%	0	0%	14	1.30%
CPSA 5	107	16%	3	0.50%	331	51%	36	6.00%	159	24%	10	1.50%	3	0.50%	649	61%
Magellan	77	24%	32	10%	52	16%	38	12%	105	33%	3	1.00%	12	4.00%	319	30%
NARBHA	9	14%	7	11%	23	35%	9	14%	15	23%	0	0%	2	3.00%	65	6.10%
Statewide	204	19%	45	4.20%	412	39%	85	8%	286	27%	16	1.50%	17	1.60%	1065	100%

Top Three Complaint Categories 85% of all q109 adult complaints fell within top three complaint categories.

Adult Complaints by Covered Service Category, Q109

Covered Service	Access to Services		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Service		Financial		Information Sharing		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Behavioral Health Day Programs	0	0%	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%	1	0.09%
Crisis Intervention Services	1	0.50%	4	21%	3	16%	6	32%	5	26%	0	0%	0	0%	19	2.00%
Inpatient Services	4	10%	4	10%	20	50%	7	18%	5	13%	3	8%	1	3.00%	44	4.10%
Medication Services	77	27%	2	0.70%	143	50%	10	3.40%	41	14%	4	1.40%	1	1.00%	278	26%
Residential Services	3	5.20%	2	4.00%	45	79%	2	4.00%	4	7.00%	1	2.00%	0	0%	57	5.30%
Support Services	41	9%	27	6.00%	140	30%	30	7%	210	46%	5	1.00%	8	2.00%	461	43%
Treatment Services	76	38%	4	2.00%	59	30%	28	14%	21	11%	3	2.00%	7	4.00%	198	20%
Rehabilitation Services	1	20%	2	40%	1	20%	1	20%	0	0%	0	0%	0	0%	5	0.50%
No Category Listed	**1**	**50%**	**0**	**0%**	**0**	**0%**	**1**	**50%**	**0**	**0%**	**0**	**0%**	**0**	**0%**	**2**	**0.20%**
Total	**204**	**100%**	**45**	**4.20%**	**412**	**39%**	**85**	**8%**	**286**	**27%**	**16**	**2.00%**	**17**	**2.00%**	**1065**	**100%**

89% of all complaints fell within the top three covered services categories.

Attachment G
Children's Performance Improvement report
Q109

Substance Abuse Treatment Program Expansion Summary

NARBHA received $127,255.41 with the substance abuse services CAP rate allocations. The funding will be used to support Matrix for Adolescents implementation at four Beta Sites and eight clinical sites. All four Beta sites are up and running (The Guidance Center, West Yavapai Guidance Clinic, Mohave Mental Health Center, Community Counseling Centers). Structural and clinical fidelity tools are being used to monitor and improve service delivery.

Cenpatico was allocated $46,216.42 for GSA 2 and $73,614.71 for GSA 4 for the expansion of substance abuse services. Cenpatico will be utilizing the CAP increase to develop additional substance abuse services in Parker. White Bison will also be providing training on culturally sensitive practices for clinicians working with Native American youth. Cenpatico will also be working with Community Intervention Associates to develop intensive Group/Based Outpatient Treatment for substance abuse. This model will include individual and family therapy.

CPSA GSA 3 received $44,253.33 with the substance abuse services CAP rate allocations. The funds will be utilized to expand substance abuse services to the San Carlos Apache Tribe.

CPSA GSA 5 received $234,973.40 with the substance abuse services CAP rate allocations. The funds will be used on several development/expansion projects. CPSA met with La Paloma to explore options for the development of an intensive outpatient program, discussions have occurred regarding the development of a program within Intermountain Centers for Human Development and CPSA is working collaboratively to expand the number of service hours for the Jewish Family and Children's Service Intensive Outpatient Program (IOP) to ensure it meets program standards.

Magellan received $471,131.44 with the substance abuse services CAP rate allocations. To date, Magellan has identified two agencies that will receive $158,334 of the CAP rate allocations for the FY09 Substance Use Services funding. 50% of the funding will be allocated to Jewish Family and Children's Services to expand and further develop their ACRA (Adolescent Community Reinforcement Approach) program and the other 50% will be utilized to build an outpatient substance abuse program targeted towards the Native American population through Native American Connections. Magellan will be tracking the service funding through claims submissions. Both agencies' programs will be identified as a specialty provider and open to all Provider Network Organizations (PNOs) for referrals.